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Table of Contents on page V

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EDITORIAL

PRIVATE LABORATORY FACILITIES ADEQUATE

J. SHELDON EASTLAND, M.D.

The Maryland Society of Pathologists has recently completed a study dealing with the use of private laboratory facilities and finds that such use falls far short of capacity. This, therefore, places State Department of Health facilities in direct competition with private laboratories whenever a physician refers a private patient who is able to pay to such state-owned and operated facilities.

At the Semiannual Meeting in September it was revealed that unused private laboratory facilities capable of handling 12,800 clinical laboratory determinations per month are available throughout the state as follows:

Central Maryland-Baltimore area	7,300
Southern Maryland area	3,000
Western Maryland-Hagerstown-Cumberland	1,500
Eastern Shore	1,000

In many cases only the medically indigent are offered these services by private, practicing physicians. In other cases, many physicians are referring private patients—those able to pay for private laboratory services—to State Health Department facilities. The State Health Department must assume the patients referred to it for laboratory determinations are unable to pay for such services on a private basis. This assumption is based on the fact that the family physician is the best person to judge a patient's ability to pay.

The remedy, therefore, lies in the hands of the individual physician in Maryland. It is he, and only he, who can take the necessary steps to curtail these referrals. Each case must be treated on its own merits. If the patient is able to pay, the referral should be made to the private laboratory facility; if he is unable to pay, then referral can and should be made to the nearest State Health Department facility. In areas where private facilities are not available, however, referral can only be made to the nearest and most adequate source.

In 1955 and again in 1956, and still once more in 1958, the House of Delegates of the Medical and Chirurgical Faculty passed a recommendation urging the State Health Department to curtail its activities in this area of the private practice of medicine.

Much has been said against socialized medicine. However, definitive action to curtail and prevent further encroachments in this area of private practice can be made by the practicing physician himself. Each physician should examine his own conscience, as well as his patient's circumstances, before making any referrals to State Health Department Laboratory facilities wherever private laboratory facilities are adequate and available.

*Medical Arts Building
Baltimore 1, Maryland*

SOPER LECTURE SERIES

The Pan American Sanitary Bureau Staff honored its director of a dozen years upon his retirement February 1, 1959 with the establishment of the Fred L. Soper Lectures in International Health.

The series includes five lectures to be given by outstanding medical personalities on successive years at leading schools of Public Health in the United States, Brazil, Chile, Mexico and Canada.

The first lecture will be given this fall by Dr. Soper himself at Johns Hopkins University's School of Hygiene, where he received his Doctorate in Public Health in 1925.

Bureau staff members will finance the lectures by voluntary donations to a special fund. Lecturers will be chosen by the host university and a committee of the PASB staff.

Object of the series is to bring Public Health students throughout the Americas into contact with scientific health authorities as outstanding as Dr. Soper.

Prior to his PASB Directorship Dr. Soper won world recognition for his work against Yellow Fever, Typhus, and Malaria in South America, Africa, the Near East and Europe. He was one of the early champions of "eradication" rather than "control" campaigns as the best means of fighting the major communicable diseases.

One of his major accomplishments was ridding Brazil of the dread Malaria-spreading *Anopheles gambiae* mosquito that invaded that country from Africa in the early 1930's.

Scientific Papers

CURRENT STATUS OF THE SO-CALLED COLLAGEN DISEASES

CURRIER McEWEN, M.D.*

One could quite accurately summarize the current status of the so-called collagen diseases by a single word—confused. However, that will hardly be sufficient for this presentation and I must elaborate on the subject.

Let us begin by making clear what I mean by the *collagen diseases* and how the term came to be used. As the concept of rheumatic fever gradually evolved from that of disease of the joints or heart to one involving structures throughout the body, it became more and more difficult to explain the widespread nature of the lesions in terms of the *organ pathology* and *cellular pathology* of Morgagni and Virchow. Then, some 25 years ago, Klinge suggested that this disease involved connective tissue as a system, and hence lesions could occur anywhere in the body where connective tissue is found. He also called attention to the peculiar, deeply eosinophilic, hyaline material found in lesions of rheumatic fever and some other diseases, which is called *fibrinoid* or *fibrinoid degeneration*. Subsequently, in 1942, Klempner coined the term *collagen diseases* to include a group of diseases in which fibrinoid occurs, basing this name on his belief that the fibrinoid was derived from altered collagen. The diseases usually included among the collagen diseases are: systemic lupus erythematosus, polyarteritis (periarteritis) nodosa, dermatomyositis, progressive systemic sclerosis (scleroderma), rheumatic fever and rheumatoid arthritis. Such a listing is easy, but attempting a definition which will suitably describe these diseases is quite another matter. One may say that the collagen diseases comprise a group of usually serious illnesses which show much overlapping among the clinical manifestations of the different members of

the group, and which also present many similarities in the histological appearance of the lesions, the most characteristic feature of which is the so-called fibrinoid change. The term *collagen diseases* has very properly been criticized on the ground that probably the major abnormality is not in collagen. For this reason it has been suggested by some that the name *connective tissue diseases* be used instead. However, this too is unsuitable because other diseases, such as fibroelastosis and degenerative joint disease clearly involve connective tissue yet do not belong in the group under discussion. Probably, therefore, it is

TABLE 1
Percentage Incidence of Various Manifestations of Systemic Lupus Erythematosus*

Manifestation	Harvey et al. (105 Pts)	Dubois (62 Pts)	Jessar et al. (44 Pts)	Shearn and Pirofsky (34 Pts)
Fever.....	86	97	95	100
Skin lesion, all types.....	85	52	68	91
Butterfly.....	39	43	—	—
Photosensitivity.....	11	40	—	58
Alopecia.....	3	51	—	—
Raynaud's.....	10	26	16	6
Arthritis and Arthralgia.....	90	90	77	85
"Typical Rheumatoid".....	27	31	—	12
Eye lesions.....	30	32	20	28
Pleurisy.....	56	60	—	50
Pneumonia, lupus.....	22	—	20	—
Cardiac lesions.....	52	—	70	—
Libman-Bachs.....	12	—	—	—
(45)	(of 38)			
Pericarditis.....	45	44	23	18
Hypertension.....	14	—	18	32
Renal.....	65	57	70	62
Psychoses.....	19	29	9	—
B.F.P.....	15	33	28	19
L.E. cell test.....	82	69	—	94
	(of 96)	(of 60)		(of 31)

* From Harvey et al.²

Presented at the One Hundred Sixtieth Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland on April 16, 1958.

* Associate Professor of Medicine, New York University College of Medicine.

TABLE 2
Estimated Predominance of Various Pathological Changes in Six "Connective Tissue Diseases"**

Disease	Chief Site of Involvement	Edema	Fibrinoid	Cellular Infiltration	Vascular Changes	Fibroblastic Proliferation
Rheumatoid arthritis	Joints Heart Serous membranes Subcutaneous tissue	+	++++ (nodules) + (synovia)	++	±	+++
Rheumatic fever		+	+	++ (Aschoff nodule)	+	++
Lupus erythematosus disseminatus	Heart Kidney Serous membranes Spleen	+++	+++	+	+	+
Periarteritis nodosa	Small arteries + arterioles in scattered sites	+ to ++ (adventitia intima)	+ to ++ (intima media)	+ to +++ (all layers)	Primary site of involvement	+++ (adventitia intima)
Scleroderma	Skin G.I. tract Heart	+ (very early lesions only)	±	±		++++
Dermatomyositis	Striated muscle Skin and subcutaneous tissue	±	±	++++	+	++

* From Calkins and Bauer.⁴

best to leave the designation as it is until such time as advancing knowledge permits a really satisfactory terminology.

CLINICAL FEATURES

The clinical features of this group of diseases are varied. However, fever, heart involvement and arthritis occur in all, although they are not common in scleroderma.

Table 1, from data presented by Harvey et al., shows the percentage incidence of various manifestations of systemic lupus erythematosus. Examples of overlapping of symptoms are very common. One may cite the case of a young woman with a typical butterfly rash and L.E. cells of lupus, who developed severe muscular weakness and tenderness and in whom muscle biopsy revealed changes in every way characteristic of dermatomyositis; or the numerous patients who are thought for years to have rheumatoid arthritis and ultimately show clinical, serological and pathological evidence of systemic lupus.

PATHOLOGICAL FEATURES

It has already been mentioned that the histological

lesions in the diseases which comprise this group are varied and widespread but show many similar features which are summarized in Table 2, modified from Calkins and Bauer. Vascular lesions are common in all. The damage may predominate in different layers of the vessel wall in such diseases as lupus and polyarteritis, but it is frequently impossible to differentiate on this basis. Similarly, the wire-loop lesion in the glomerulus, which has so long been accepted as a prominent feature of systemic lupus erythematosus, we have seen in apparently identical form in polyarteritis nodosa and in somewhat modified form in scleroderma. As regards the fibrinoid change, it has already been noted that it is considered to be a pathological common denominator of these diseases.

The exact nature of fibrinoid remains uncertain. It was at first thought to be altered collagen. However, the studies of Ziff et al. showed that fibrinoid contains essentially no hydroxyproline, an amino acid peculiar to collagen, and it is therefore extremely unlikely that fibrinoid is derived from collagen. Altshuler and Angevine have hypothesized that fibrinoid is altered ground substance—perhaps re-

sulting from a combination between the acid mucopolysaccharides and basic protamines from the blood. A third theory is that of Thomas whose studies support the view that fibrinoid contains altered fibrinogen. Investigations reported by Gitlin and his colleagues provide additional evidence that constituents of plasma such as fibrinogen may contribute to the formation of fibrinoid in a variety of collagen-vascular lesions. Finally, it is quite possible that the amorphous, deeply eosinophilic, hyaline material to which the name fibrinoid has been given, is not the same substance in every disease in which it is found.

CAUSATION AND PATHOGENESIS

Little of certainty is known, also, about these aspects of the collagen diseases. Indeed, the cause is not fully known for any member of the group, and for most of them our ignorance as to etiology is complete. In the case of rheumatic fever, it is now clear that infection with group A hemolytic streptococci is an essential part of the mechanism. Beyond this, however, there is no understanding of why some such infections are followed by rheumatic fever and others are not. In the case of polyarteritis nodosa, the work of Rich and others indicates that a fatal illness with histological lesions resembling polyarteritis can result from hypersensitivity to foreign proteins, sulfonamides and antibiotics, but it is not certain that this hypersensitivity angiitis is identical with primary polyarteritis nodosa.

Certainly there is considerable evidence that this group of diseases may be associated in some way with hypersensitivity, but the relationship is, at best, unclear. Interest has focused also on the finding in some of these diseases of phenomena based on the appearance of abnormal proteins. In systemic lupus, for example, the extremely interesting and probably specific so-called L.E. cell phenomenon is dependent on such a protein, which has recently been demonstrated to be an antibody to certain nuclear constituents, while in rheumatoid arthritis there exists in the serum a high molecular weight complex of gamma globulin which by its ability to react with gamma globulin is responsible for the sheep erythrocyte agglutination reaction and other similar serologic tests characteristic of this disease. Of particular interest in this regard are the studies of Dr. J. Earl Moore on patients exhibiting biological false positive serological reactions for syphilis. In a group of 87 such individuals followed for periods of three to 20 years, a highly significant number of them were

TABLE 3
*Subsequent Illness in Chronic BFP Phenomenon**

Forty per cent of white persons of upper socio-economic level with routinely discovered positive STS were BFP reactors. Of 110 BFP reactors, 70 per cent were females and a majority were in the 15 to 35 year age group.

Among 87 observed for 3 to 20 years

- 7 per cent developed systemic lupus with positive L.E. test;
- 7 per cent developed rheumatoid arthritis;
- 17 per cent developed clinical evidence of SLE but with negative L.E. test;
- 25 per cent developed illness consistent with early, mild SLE with negative L.E. test;
- 7 per cent developed bizarre undiagnosed serious illness;
- 40 per cent had remained well up to the time of the report;
- 82 per cent have dysgammaglobulinemia;
- 10 per cent had no clinical or laboratory abnormality.

* After data of J. E. Moore.^{3, 17}

found to develop distinct rheumatoid arthritis or systemic lupus or illnesses suggestive of the latter (see Table 3).

Another question which remains to be answered is whether one is warranted in considering these diseases truly related to one another. In the case of some, the evidence is not very strong; in others, however, such as systemic lupus and rheumatoid arthritis, the occurrence of clinical, serological, and laboratory manifestations of both in a single patient is so common that one cannot accept coincidence as an explanation. Excluding coincidence, three other explanations of relationship must be considered. First is the possibility that the diseases have no pathogenetic relationship as such, but tend to occur in the same patients because one disease predisposes to others of the group. There is little to support this unlikely suggestion, however.

More plausible are two other theoretical explanations: first, that these diseases represent merely different manifestations of a single entity and, second, that they are distinct but based on similar underlying mechanisms. According to the latter view, for example, the basic mechanism may be tissue hypersensitivity involving different antigens, different target tissues or different parts of the walls of blood vessels or vessels of different sizes. Obviously such explanations must remain purely speculative until the diseases and their nature are better understood.

TREATMENT

Finally let us consider briefly the current status of treatment of the collagen diseases. In the case of

rheumatic fever there is now available a highly successful means of prevention by the use of continuous penicillin prophylaxis, and treatment of the established attack of rheumatic fever with corticosteroids, while still of questionable value, does offer hope. The value of corticosteroids in the treatment of rheumatoid arthritis is somewhat unsettled also. It can be said with assurance that doses of corticosteroids which can be safely administered over long periods do not prevent the progression of destructive changes, but it is equally clear that steroid therapy can be of very great help when properly given.

Scleroderma, unfortunately, responds little, if at all, to corticosteroid therapy, and the response of dermatomyositis is variable. In some cases, however, cortisone has helped carry a patient over an acute episode of dermatomyositis which might otherwise have been fatal, and has enabled the patient to enter a prolonged and complete or nearly complete remission. The same has been repeatedly observed in polyarteritis nodosum.

Perhaps in no other disease of this group have the benefits of cortisone therapy been as striking as in systemic lupus erythematosus. It is very probable that corticosteroids do not alter the underlying mechanism of the disease, which has a strong natural tendency to go into spontaneous remissions between the acute flare-ups. In the past, patients often died during the more florid exacerbations. Today, however, intensive therapy with cortisone or the similar newer agents can suppress the acute and fatal manifestations of disease during the critical period and carry the patient on until the disease undergoes spontaneous remission. Furthermore, the patient often can then be maintained in fairly good health for years with low doses of steroid, perhaps supplemented with 250 to 500 mg. daily of chloroquin.

Thus in only one of these diseases, scleroderma, has there been no major improvement in therapy during the past few years. For the others the current status of therapy is one of encouragement and one may hope with considerable confidence that treatment of all the collagen diseases will make still greater progress in the years ahead.

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MEDICAL AND SURGICAL TREATMENT OF TUBERCULOSIS

PATRICK B. STOREY, M.D.*

We continue to see great progress in our method of management of tuberculosis, to the point where it continues to be a disease treated by the specialist rather than a disease treated by the generalist. New knowledge about old drugs and old methods of treatment of the disease, knowledge about new drugs constantly being developed, and constant development of knowledge with reference to our surgical limitations and horizons, all with a good bit more backing now in terms of follow-up of our treated patients, allow us to constantly adjust our position in the treatment of the disease. Indeed in this very year, the VA has adopted a new scheme for classifying its cases of pulmonary tuberculosis, and this new scheme of classification gives its proper due to the importance of the cavity in the management of this disease.

Group I—No Cavity

Group II—Single Cavity:

- A. 2.0 cm. or less in diameter.
- B. More than 2.0 cm. and less than 4.0 cm. in diameter.
- C. 4.0 cm. or more in diameter.

Group III—Multiple Cavities:

- A. Largest cavity 2.0 cm. or less in diameter.
- B. Largest cavity more than 2.0 cm. and less than 4.0 cm. in diameter.
- C. Largest cavity 4.0 cm. or more in diameter.

Fig. 1. VA-AF classification of pulmonary tuberculosis designed from point of view of evaluation of drug therapy regimens.

Fig. 1 illustrates the new classification of pulmonary tuberculosis, and you see that the cases are divided actually into three groups. The first group includes those patients who have no cavity, whether

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they are minimal cases by NTA criteria or moderately advanced. This is the group of cases which is now relatively easy to treat as far as management goes. Actually the main hazard a patient with minimal tuberculosis runs now is the hazard of being called "inactive" and allowed to escape medical surveillance without therapy. If adequate chemotherapy can be instituted in these cases of minimal tuberculosis, and be continued for a long enough period of time, these patients should do beautifully. Seldom should they need resectional surgery, and they will need very little in the way of bed rest. Bringing them into the hospital for the purpose of diagnosis and perhaps the purpose of removing them from whatever noxious environment may exist on the outside, and perhaps giving them bed rest, depending on what we call the "hotness" of the disease, for a short period of time, may be all that is necessary in the management of these minimal cases.

The second group are the patients who have a single cavity, and you will notice they are subdivided according to cavity size into those who have the small, single cavity—2 cm. or less; those with medium size cavity up to 4 cm. in size; and those with the really big cavity which is the cavity beyond 4 cm. in size.

The third group, that of the patients with multiple cavities, again is subdivided according to the size of the largest cavity. Now this is not according to total diameter of cavity which is the method we use in the NTA classification. This is the size of the largest cavity.

Fig. 2 was developed by Dr. Tucker from the general regimens of the VA-Army-Navy study of the treatment of pulmonary tuberculosis. Now, actually poured into this massive study of the effectiveness of three regimens, SM-INH, INH-PAS, SM-PAS, were some 3,000 patients, and this study is a line graph showing the incidence of cavity closure

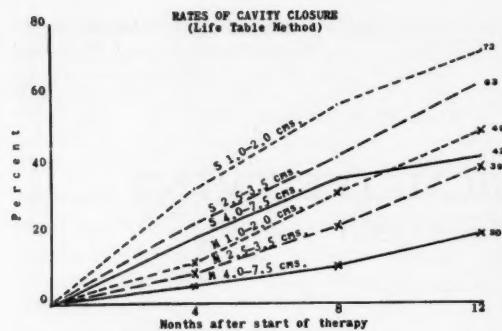


FIG. 2. The incidence of cavity closure related to number of cavities and size of cavities.

under drug therapy. You see the percentage of patients who had cavity closure on the left, and the duration of treatment in months expressed along the base.

Now, note that there are two important factors in determining the prognosis for cavity closure; 1) the number of cavities, i.e. whether the patient had a single cavity or multiple cavities, and 2) the size of the cavity. At the six month point of observation you will note that for the single cavity which is 2 cm. or less in size, at six months of therapy the incidence of closure of such cavities is only in the order of 50 per cent. If you go out to 12 months of observation, you have 72 per cent closure of the single small cavity. So the existence of the cavity creates a tremendous problem in the management of these patients with pulmonary tuberculosis.

Also note the striking importance of multiplicity, i.e., the existence of more than one cavity, because when you get down to where you have patients who have multiple small cavities with the largest cavity measuring 2 cm. in size, the prognosis for closure of all cavities at six months is less than is the prognosis for closure of the single large cavity. So the situation becomes worse as the patient's cavity increases in size and as there is more than one cavity.

Now, keeping this illustration in mind, I would like to introduce another factor in the management of pulmonary tuberculosis, and that is the balance between "destruction" produced by the disease and "distribution" of the patient's disease. Any bridge player knows the significance of distribution. He can have the most powerful hand in the game and distribution can get him every time. So, frequently in tuberculosis, the treatment dilemma may not be the destruction caused by the disease and the sever-

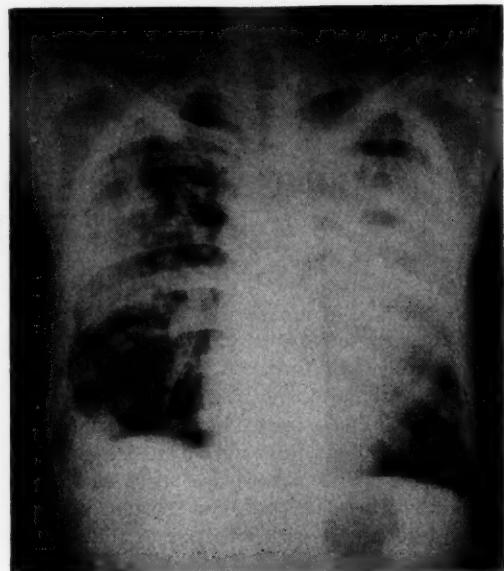


FIG. 3. Admission x-ray of first patient described in text.

ity of the constitutional response to the disease, but the distribution of the patient's disease.

Now, there is all the difference in the world in the patient (Fig. 3) who has extensive tuberculosis, "hot" tuberculosis. Notice the degree of cavitation he has in the left upper lobe, with spread down through the left lung and across with extensive involvement of the right lung.

Fig. 4 shows a younger man who has what amounts to a destroyed left lung. This patient was treated with triple therapy, with daily streptomycin, isoniazid, and PAS, and over a three month period of time showed just about no response so far as his clinical effect went and so far as his X-ray was concerned. Fig. 5 shows his status at the end of three months treatment. It's a lighter X-ray, but there has been no change in the left side. On the right side there has been contraction of each of the areas of spread of his tuberculosis. He was a very sick individual who had shown no pickup at all. This patient's problem, because of the favorable distribution of the disease, was handled beautifully by a left pneumonectomy at three months of treatment when his sputum was still positive following the removal of a lung in which the only area of normal tissue was found immediately above the diaphragm by the pathologist. This patient showed striking improvement and eventually graduated from the hospital to normal activity at home.

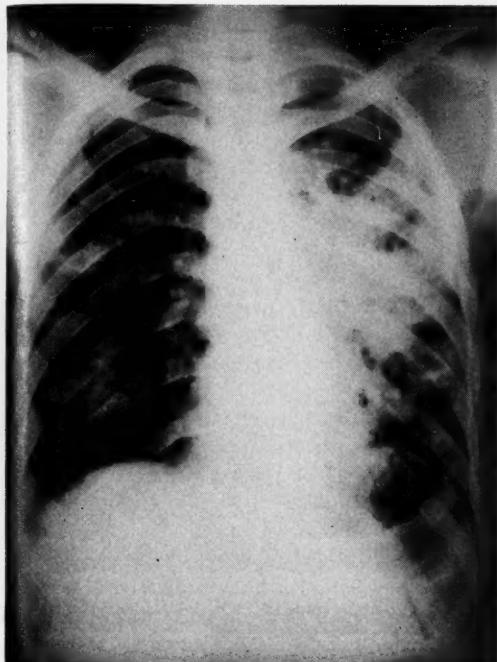


FIG. 4. Admission x-ray of second patient described in text.

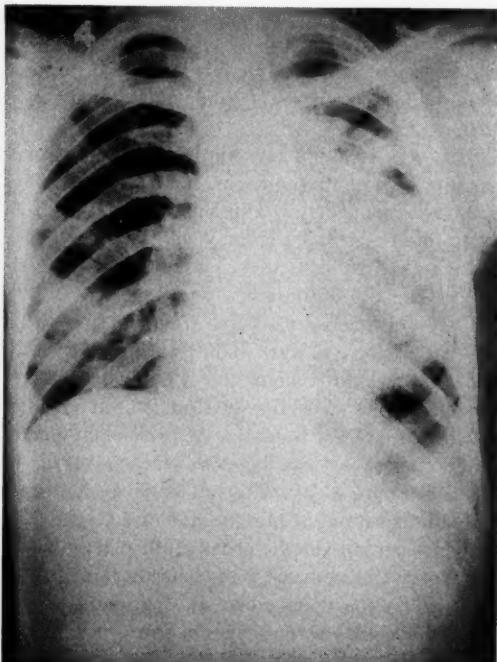


FIG. 5. X-ray of same patient as in Fig. 4 at three months of treatment.

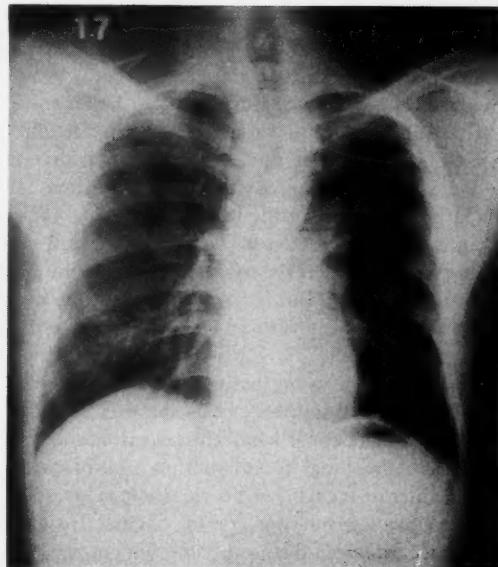


FIG. 6. X-ray of same patient as in Fig. 3 at 18 months of chemotherapy.

Fig. 6 shows the course with the antecedent patient. This is the patient whose distribution was against him at the start, who under the influence of 18 months of chemotherapy showed remarkable clearing of disease in both lungs with a residual cavity in his left apex. The response to treatment here was good, but the patient was left with a cavitary residual. This was handled by the performance

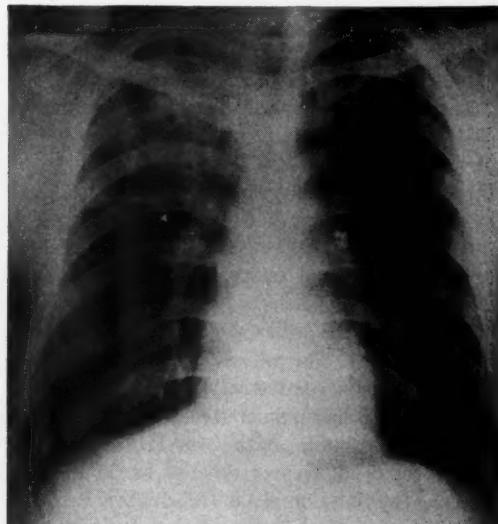


FIG. 7. Disease localized to RUL as described in text.

of left upper lobectomy to remove the residual cavity. This is probably the proper way to treat such disseminated disease. One treats it with chemotherapy for a reversion of all that can be reverted, and then one resorts to surgical therapy for residual changes of destruction such as the persistent cavity.

We still accept the cavity as an indication for surgery whether or not the sputum is positive. If the sputum is negative then we have what we call the open negative case. If the patient is operable this is a surgical indication. But let us return from this situation to the patient with localized destructive disease.

Fig. 7 shows a young patient, 23 years old, who had as you see, multiple cavities and extensive disease of his right upper lobe. The lateral film in this situation showed that he had multiple areas of spread in the anterior segment of his right upper lobe, but his superior segment was free of disease. He had, therefore, extensive disease of the right upper lobe with multiple cavities. This leads immediately to the third concept that I wish to develop, and that is we can and should do early resectional surgery in certain selected cases.

Perhaps the most important point to make is that we can operate on such a patient as the one I have just shown in six weeks rather than in six months. Whether or not we should do such early surgery obviously depends upon the merits of each individual case, but the main point to establish, and the one I would like to establish, is that we can do it.

These three developments that I have mentioned: 1) knowledge of the poor potential of the cavity to close under chemotherapy, a potential which is less and less with increase in number and size of cavities; 2) the realization of the significance of distribution of the disease balanced with destruction; and 3) knowledge that resectional surgery can be done early when drug susceptibility is actually at its maximum in the original treatment of cases, and regardless of sputum positivity, allows much more freedom in planning our overall treatment program than we have had previously.

Fig. 8 shows the presence of a large cavity in the right upper lobe. The patient was thought to have advanced pulmonary tuberculosis. His chemotherapy for tuberculosis had been started prior to his admission to the hospital, and his P.P.D. was positive, and we could not recover tubercle bacilli from his sputum. The question of non-tuberculous lung disease arose, and the question of bronchogenic carci-

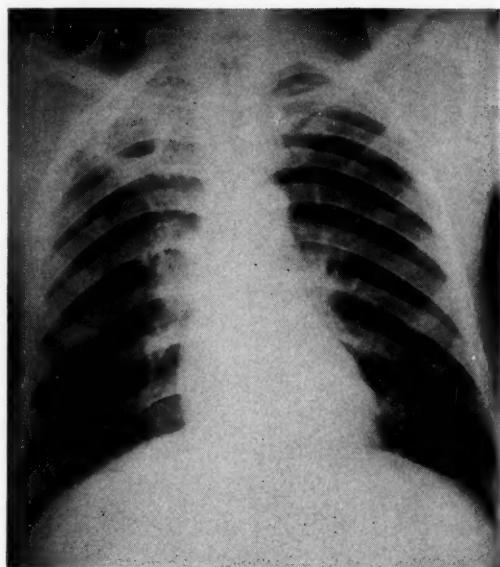


FIG. 8. Cavitary process RUL of undiagnosed cause. Sputum negative for tubercle bacilli.

noma might have arisen. The point is that the likelihood in this case of its being TB should not contraindicate early surgery under antituberculous chemotherapy. Indeed, early resection might well be the treatment of choice for this individual for more than diagnostic purpose, e.g. for his tuberculosis as well.

Just very briefly a few words about the chemotherapy we use. Streptomycin, of course, is still very much with us. There is a distinct trend away from using intermittent streptomycin. The one gram twice weekly regimens are being replaced in popularity by the daily streptomycin regimens.

INH is our most remarkable drug. There is still a lot that we have to learn about isoniazid. Presently under study throughout the VA Armed Forces cooperative group is the question of the value of using high doses of isoniazid. At present, in normal usage, one uses a 4 mg./kg. dose which comes out to about 300 mgs. a day. This is a kind of across-the-table dose. But recent work has indicated that many patients, perhaps in the order of 40 per cent, will metabolize this isoniazid to its inactive form acetylisoniazid to the point where the patient does not develop adequate serum levels of free isoniazid, the effective form of the drug. The study that we have undertaken in the VA is one that will compare the

effect of 16 mg. per kg., or 1000 to 1200 mg. per day in combination with PAS against the standard INH-PAS regimen. When you get to high doses of isoniazid, you develop the problem of neurotoxicity, and this almost always manifests itself as peripheral neuritis. To counteract this, or to prevent it, we administer pyridoxine to all of these patients who are getting isoniazid above 300 mg. per day. PAS is available in many forms for those whose GI tracts have difficulty tolerating the drug. We are very much interested in the influence of PAS, a drug which is also acetylated, on the metabolism of isoniazid, and there is very good evidence that PAS blocks the acetylating effects on isoniazid, and that patients who get isoniazid and PAS together actually have higher blood levels of free isoniazid. This may be the secret of success for the drug combination of isoniazid and PAS.

Viomycin and pyazinamide, or PZA, are drugs we have had considerable experience with. We call them secondary drugs, and actually we use them mostly for more or less short term treatment in the management of problems that come up in the drawn out courses of some of our patients. For example, a patient who is a re-treatment case, who has had previous treatment and who is probably resistant to streptomycin and isoniazid, but for whom surgery is in the offing, might well have his pre-surgical treatment consist of the viomycin and PZA combination, a combination he is not likely to have had previously.

Cycloserine is now three years old and I must say, has not yet found its place in the treatment of tuberculosis. We used it in a one gram a day dose, and fully eight per cent of the patients treated in the VA Army study of cycloserine developed convulsive seizures. We have used it in a half gram per day dose (it has not been used alone, it has been used in combination with isoniazid), and there is considerable evidence now that the combination of the half gram of cycloserine with isoniazid is not as effective as isoniazid-PAS. Now, this is from the VA-AF controlled study of cycloserine-isoniazid, in which the effectiveness of this regimen is compared with that of INH-PAS in a simultaneously treated group of patients.

Table 1 shows the incidence of worsening by X-ray while under treatment. The group to the left includes patients treated with INH-PAS, of whom there were 245 who started treatment. On the right are the patients treated with CS-INH, and there were 251

TABLE 1
The Incidence of X-ray Worsening in Patients With Cavitary Tuberculosis Treated With CS-INH as Compared With INH-PAS. VA-AF Research Studies XII and XIII

Month of Treatment	Number of Cases	INH-PAS		CS-INH	
		Worsening by X-ray		Number of Cases	Worsening by X-ray
		Number	Per Cent		
1	245	2	0.8	251	3
2	231	0	0	240	7
3	207	0	0	223	1
4	192	1	0.5	213	4
5	132	0	0	141	2
6	122	0	0	126	2
7	101	0	0	106	1
8	90	0	0	92	2
	245	3	1.2	251	22
Calculated Risk		1%		12%	

who started treatment. In the center of each group are the number of patients who showed worsening by X-ray under treatment. You will notice that there were three instances in the INH-PAS group. The actual incidence was 1.2 per cent of the original number starting treatment, for a calculated risk of worsening of 1.0 per cent.

In the CS-INH group there were 22 patients who showed worsening by X-ray, for a calculated risk of 12 per cent worsening by X-ray under CS-INH therapy. You would think that this is pretty cogent evidence that the CS-INH therapy of tuberculosis leaves something to be desired.

The most promising new drugs are kanamycin and thiocarbanidine. We know just about nothing at present about thiocarbanidine as far as human treatment is concerned. With kanamycin, studies are being conducted up at Bellevue Hospital and I have seen those cases recently reviewed. The drug has remarkably little toxicity. The only unexplained phenomenon so far is a high incidence of casts in the urine, but with no other evidence of renal damage. Kanamycin has been accepted for trial in the VA Study Group and we will probably have more information on it about the time of the next meeting in February. We are hopeful that this may become a useful agent.

3900 Loch Raven Boulevard
Baltimore 18, Maryland

ARTICLES OF INTEREST

OBJECTIVES OF NURSING EDUCATION

SISTER BERNADETTE ARMIGER, R.N., M.S.

The approach of the centenary of the founding of modern nursing is an appropriate time to reappraise the goals of nursing education then and now. Florence Nightingale employed the word *training* rather than the broader term *education* to characterize the aims of the Nightingale School founded in 1860.

Training is to teach the nurse to help the patient to live. . . . Training is to teach the nurse to know her business, that is, to observe exactly, to understand . . . in such stupendous issues as life and death, health and disease. Training has to make her, not servile, but loyal to medical orders and authorities. True loyalty to orders cannot be without the independent sense or energy of responsibility which alone secures true trustworthiness. Training is to teach the nurse how to handle the agencies within our control which restore health and life, in strict, intelligent obedience to the physician's or surgeon's power and knowledge. . . . Training must show her how the effects on life of nursing may be calculated with a nice precision—such care or carelessness, such a sick-rate, such a duration of case, such a death-rate.¹

Later in the same paper Miss Nightingale emphasized the spiritual and moral values which she placed before technical and intellectual competence.

Discipline is the essence of moral training. . . . It is education, instruction, training—all that goes to the full development of our faculties, moral, physical, and spiritual, not only for this life, but looking on this life as the training-ground for the future and higher life.²

The Nightingale nurse, product of this training, was not to be an automaton, nor was she to be a servant. The relationship of the nurse to the doctor was to be that of a colleague—one who was to work *with* the doctor, intelligently forwarding his program of therapy, but at the same time practicing nursing as a vocation in its own right with the specific functions and responsibilities which set it apart. It is not difficult to read into the words of the founder of modern nursing many of the concepts, values, and skills which nursing educators strive to inculcate today—understanding of comprehensive nursing and promotion of positive health; habits of intelligent

obedience, loyalty, trustworthiness, and a sense of responsibility; ability to think critically, to use discriminating judgment, and to analyze statistical data.

Basic to the principles held by Miss Nightingale was the establishment of an *independent* school; that is, an institution developed primarily for educational purposes. The Nightingale School, though using the facilities of St. Thomas's Hospital in London, kept its own identity as an educational institution. Through endowment by the Nightingale Fund and through centralization of authority in the matron who was head of the school, Florence Nightingale insured its independent status.

Like all great educators Florence Nightingale realized the pre-eminence of realistic learning situations. Teaching at the bedside was correctly appraised as the method par excellence for learning comprehensive nursing. Quoting a successful physician's statement, "I do not treat pneumonia. I treat the person who has pneumonia," Florence Nightingale concludes: "This is the reason why nursing proper can only be taught by the patient's bedside."³

Why did the emerging American pattern of nursing education veer from the sound educational norms proposed by the founder of modern nursing? The introduction of the Nightingale System at Bellevue in 1873 was a beginning in the right direction. However, the urgency of human need in the growing American economy, with its inadequate hospital facilities and untrained servant-nurses, resulted in the indiscriminate adoption of the training school as an answer to the problem of a low-cost supply of nursing service. Training schools in the United States in the two decades following 1873 must

¹ Florence Nightingale, "Sick-Nursing and Health-Nursing," quoted in Lucy Ridgeley Seymer, *Selected Writings of Florence Nightingale* (New York: Macmillan Co., 1954), pp. 357-58.

² *Ibid.*

³ *Ibid.* p. 355.

roomed, with few exceptions, for economic reasons predominantly. The service of the "pupil-nurses" was less costly than any other type of auxiliary and unquestionably more stable.

As hospitals took over the administration of these schools the enmeshing of the nursing school with the hospital nursing service distorted the purposes of training nurses. This service-centered education could only result in anomalies within the developing pattern.

Nursing educators from the earliest days of their organized action have striven to correct this rapidly rising hazard to educational standards. Fortunately, they have been aided by members of the medical profession who recognized in substandard nurses' training schools a problem similar to the havoc that Flexner pointed out in 1910 with respect to medicine's "diploma mills."⁴ Through the years the attempts to make nursing schools institutions for *learning* nursing have occasionally been countered by objections—

... that the old nurses were good enough... that the new nurses would be overtaught... that they would soon think they know full as much or more than doctors... and would actually study medicine while disguised in nurses' caps.⁵

In the re-direction of the course of nursing education, immeasurable assistance has likewise come from foundations such as Rockefeller and Russell-Sage. However, the leadership has always been within the profession. The American Nurses' Association filled the first basic need in evaluating objectives for its educational discipline by defining the functions, standards, and qualifications for 13 different positions within professional nursing.⁶ The National League for Nursing made a comprehensive study of the stated objectives of fully accredited schools in 1953. The results of this study have been published under the title *Objectives of Educational Programs in Nursing*.⁷

The administrators of schools of nursing must ponder well their own philosophy and purposes in accordance with the unique contribution they can make. While realizing that no single source will provide the data for the formulation of the objectives of nursing education in the complex society its graduates will serve, nursing, like general education, studies many factors. Nursing education is concerned with the needs and interests of the learner as well as with the needs of contemporary society. It engages

in introspection and research to answer satisfactorily the question: What is nursing? To be wholly satisfied with the definitions of the past would be comparable to the use of the "leeches and blisters" of Florence Nightingale's day to treat the ills of the atomic age!

The objectives of nursing education logically evolve from its philosophy. Nursing education, accordingly, gives consideration to the dignity of the human personality and to the supernatural destiny of its students and of those they serve. Nursing education aims to develop all aspects of student growth: physical, mental, spiritual, moral, cultural, social, personal, and professional.

Finally, in making choice of the objectives of nursing education, experts use the findings of educational psychology as a basis for understanding how students learn as well as how they adapt to the learning environment. Fundamental to this is the realization that the nursing student is a *learner*, and that nursing education proposes to fit her to give service as a graduate nurse. Education aims to bring about changes in the behavior of its students—behavior considered in its broadest sense, as the ways students think, feel, and act. What, then, is the behavior nursing education aims to produce?

Observation of the learner who applies for nursing education frequently reveals behavior patterns tainted by the impersonal, mechanized, chaotic society of today. Serious thought must be given to the choice of objectives which will change and direct behavior implanted by early exposure, particularly through television, to problems undreamed of a generation ago. Multiplying courses in communication skills and interpersonal relations in nursing alone will not correct the casual vocabulary and irresponsible attitudes that stultify the very title "nurse."

Ralph Tyler refers to the objectives of education as the consciously willed goals and the considered

⁴ Abraham Flexner, *Medical Education in the United States and Canada* cited in Mary M. Roberts, *American Nursing* (New York: Macmillan Co., 1954), p. 50.

⁵ Dr. W. Gilman Thompson, *Training Schools for Nurses* (Summary of the work of twenty-two schools, 1883), quoted in Isabel M. Stewart, *The Education of Nurses*. (New York: Macmillan Co., 1943), p. 94.

⁶ American Nurses' Association, "All Sections Stressing Use of FS & Q Statements," *A.N.A. in Review*, Vol. V (Fall, 1957), p. 3.

⁷ National League for Nursing, (New York: National League for Nursing, 1955), 22 p.

value judgments of those responsible for the school.⁸ Nursing faculty members know the importance of attitudes of respect for patients and for co-workers, and of habits of truthfulness and of responsibility. In order that these values be similarly esteemed by students, faculty personnel must translate the ends they desire into clearly stated objectives of the school and of each course, or to use the terms of the time—into "king-size and regular-size" objectives.

Doctors, educators, and other representatives of the community have much to contribute to the formulation and/or revision of aims of the school of nursing. Not only can they bring the wealth of their experience to the task, but they, too, will gain by the clarification of goals necessitated by the changing role of the nurse in an evolving society and by the changeless status of the student in any milieu. Such cooperation in the statement of objectives will inevitably win understanding, acceptance, and support. The National League for Nursing cites another outcome of such participation, namely, that participants will "more readily see the relationship between an adequately financed educational program in nursing and the nursing services they are demanding."⁹

The approach of the century-milestone of nursing education is a strategic time for thoughtful re-consideration of its objectives. A closely related desideratum is receptiveness to the fact that nursing is not going counter to its best traditions in the changes observed in nursing functions today. To decry the "passing of the bedside nurse" without recognition of the enlarging scope, the expanding functions, and the increasing demands for nursing is to overlook the

obvious. As another century of nursing education begins, objectives must focus on the nurse's role in rehabilitation and in occupational health, and these considered on the international as well as the national scene. As the nurse today gives services once deemed the province of the doctor, her objectives must delineate not only the technological aspect, but also the exacting scientific rationale, and the equally vital finesse which should be brought to bear on the response of the human person. As differentiation of functions within the nursing service department emerges, objectives must determine the preparation of the professional nurse for directing practical nurses, aides, and other sub-professional personnel.

Achievement of this task involves intensive theoretical and operational phases. Nursing educators are not approaching it with an esoteric purpose. Especially do they desire that the medical profession share their viewpoint and support their effort in this new view of the changing functions and the specific objectives of the nursing profession. The founder of modern nursing wrote in 1893:

We are only on the threshold of nursing . . . in the future . . . may a better way be opened. . . . Are we walking to the future or to the past? Are we progressing or are we stereotyping? . . . Don't let us stereotype mediocrity!¹⁰

Even today we are on the threshold of nursing. But even today we repudiate stereotyped mediocrity.

St. Joseph College
Emmitsburg, Maryland

⁸ *Basic Principles of Curriculum and Instruction*, (Chicago: The University of Chicago Press, 1950), p. 3.

⁹ National League for Nursing, *op. cit.* p. 7.

¹⁰ Florence Nightingale, *op. cit.* pp. 366-68.

"Look back along the endless corridors of time and you will see that four things have built civilization: the spirit of religion, the spirit of creative art, the spirit of research and the spirit of business enterprise."

Dr. Neil Carothers

NATIONAL INTER-PROFESSIONAL CODE FOR PHYSICIANS AND ATTORNEYS*

PREAMBLE

The provisions of this Code are intended as guides for physicians and attorneys in their inter-related practice in the areas covered by its provisions. They are not laws, but suggested rules of conduct for members of the two professions, subject to the principles of medical and legal ethics and the rules of law prescribed for their individual conduct.

This Code constitutes the recognition that, with the growing inter-relationship of medicine and law, it is inevitable that physicians and attorneys will be drawn into steadily increasing association. It will serve its purpose if it promotes the public welfare, improves the practical working relationships of the two professions, and facilitates the administration of justice.

MEDICAL REPORTS

The physicians upon proper authorization should promptly furnish the attorney with a complete medical report, and should realize that delays in providing medical information may prejudice the opportunity of the patient either to settle his claim or suit, delay the trial of a case, or cause additional expense or the loss of important testimony.

The attorney should give the physician reasonable notice of the need for a report and clearly specify the medical information which he seeks.

CONFERENCES

It is the duty of each profession to present fairly and adequately the medical information involved in legal controversies. To that end the practice of discussion in advance of the trial between the physician and the attorney is encouraged and recommended. Such discussion should be had in all instances unless it is mutually agreed that it is unnecessary.

Conferences should be held at a time and place mutually convenient to the parties. The attorney and the physician should fully disclose and discuss the medical information involved in the controversy.

* Adopted by the American Medical Association and the American Bar Association in June, 1958 and August, 1958 respectively at their annual meetings.

Reprinted from the *Journal of the American Medical Association*, 168: 12, November 22, 1958.

SUBPOENA FOR MEDICAL WITNESS

Because of conditions in a particular case or jurisdiction or because of the necessity for protecting himself or his client, the attorney is sometimes required to subpoena the physician as a witness. Although the physician should not take offense at being subpoenaed the attorney should not cause the subpoena to be issued without prior notification to the physician. The duty of the physician is the same as that of any other person to respond to judicial process.

ARRANGEMENTS FOR COURT APPEARANCES

While it is recognized that the conduct of the business of the courts cannot depend upon the convenience of litigants, lawyers or witnesses, arrangements can and should be made for the attendance of the physician as a witness which take into consideration the professional demands upon his time. Such arrangements contemplate reasonable notice to the physician of the intention to call him as a witness and to advise him by telephone, after the trial has commenced, of the approximate time of his required attendance. The attorney should make every effort to conserve the time of the physician.

PHYSICIAN CALLED AS WITNESS

The attorney and the physician should treat one another with dignity and respect in the courtroom. The physician should testify solely as to the medical facts in the case and should frankly state his medical opinion. He should never be an advocate and should realize that his testimony is intended to enlighten rather than to impress or prejudice the court or the jury.

It is improper for the attorney to abuse a medical witness or to seek to influence his medical opinion. Established rules of evidence afford ample opportunity to test the qualifications, competence and credibility of a medical witness; and it is always improper and unnecessary for the attorney to embarrass or harass the physician.

FEES FOR SERVICES OF PHYSICIAN RELATIVE TO LITIGATION

The physician is entitled to reasonable compensation for time spent in conferences, preparation of

medical reports, and for court or other appearances. These are proper and necessary items of expense in litigation involving medical questions. The amount of the physician's fee should never be contingent upon the outcome of the case or the amount of damages awarded.

PAYMENT OF MEDICAL FEES

The attorney should do everything possible to assure payment for services rendered by the physician for himself or his client. When the physician has not been fully paid the attorney should request permission of the patient to pay the physician from any recovery which the attorney may receive in behalf of the patient.

IMPLEMENTATION OF THIS CODE AT STATE AND LOCAL LEVELS

In the event similar action has not already been

taken this Code should, in the public interest, be appropriately implemented at state and local levels for the purpose of improving the interprofessional relationship between the legal and medical professions.

CONSIDERATION AND DISPOSITION OF COMPLAINTS

The public airing of any complaint or criticism by a member of one profession against the other profession or any of its members is to be deplored. Such complaints or criticism, including complaints of the violation of the principles of this Code, should be referred by the complaining doctor or lawyer through his own association to the appropriate association of the other profession; and all such complaints or criticism should be promptly and adequately processed by the association receiving them.

OREGON CANCER CONFERENCE

An Oregon Cancer Conference is being held July 16 and 17, 1959 in Portland under the joint sponsorship of the Oregon State Medical Society, the Oregon Division of the American Cancer Society, the University of Oregon Medical School and the Oregon Academy of General Practice. The Conference is planned for midsummer as a special feature of the Oregon Centennial celebration.

MEDICAL USE OF HYPNOSIS

The history of hypnosis since the time of Mesmer has been characterized by a series of curious cycles alternating between great interest and almost complete rejection. This phenomenon in itself is an indication of the somewhat mystical aura that has surrounded the subject throughout the years. Recently, owing to a concatenation of circumstances, there has been a reawakened interest in hypnosis. In part the experiences of World War II contributed to this interest.

The Council on Mental Health of the American Medical Association has for some years received numerous inquiries from physicians throughout the country relating to the subject of hypnosis, many of them asking for information regarding training programs in this area. A group of serious workers in medicine has been reporting on various aspects of the utilization of hypnosis. In addition, the dental profession has become interested in its use in relation to its own practice. Concurrently "fringe" groups have been exploiting hypnosis through the press, radio, and television. Over-popularization in this as in other areas of medicine usually leads to over-simplification. Over-dramatized events are seized upon to the general detriment of sober scientific work.

Recently a Subcommittee of the British Medical Association issued an excellent report* with which the Council is in essential agreement.

In view of the total situation, the Council on Mental Health of the AMA constituted itself as a Committee of the Whole to study the medical use of hypnosis. Some outstanding authorities in this field were invited to participate in several Committee meetings, and in addition others were requested to give their opinions through correspondence. The Council expresses its thanks and appreciation to them for their excellent collaboration in this study. It is to be emphasized that the responsibility for this report and the recommendations contained therein are those of the Council.

The work of the Hypnosis Committee was limited to the specific theme of the medical use of hypnosis in its therapeutic aspects since this seemed to be the most relevant area for the Council's consideration.

Reprinted from the *Journal of the American Medical Association*, 168: 2, September 13, 1958.

* British Medical Journal, April 23, 1955 (See also summary in J.A.M.A., July 30, 1955, p. 1189).

I. There was unanimous agreement that there was no need at this time to question the validity of the various phenomena elicited by hypnotic techniques. Actually, in the literature of hypnosis practically all of these phenomena have been noted in one way or another since the time of Mesmer. In spite of this, however, it is still difficult to arrive at a formulation of hypnosis that is completely satisfactory. The Subcommittee of the British Medical Association presented the following definition with which there was agreement in general:

"A temporary condition of altered attention in the subject which may be induced by another person and in which a variety of phenomena may appear spontaneously or in response to verbal or other stimuli. These phenomena include alterations in consciousness and memory, increased susceptibility to suggestion, and the production in the subject of responses and ideas unfamiliar to him in his usual state of mind. Further, phenomena such as anesthesia, paralysis, and the rigidity of muscles, and vaso-motor changes can be produced and removed in the hypnotic state."

The Committee emphasized certain regressive aspects of hypnosis. It also stressed the fact that hypnotic phenomena were of a wide variety and should not be limited only to the so-called trance state.

In order to begin to understand these phenomena it is necessary to place hypnosis within the general framework of psychodynamic psychology and psychiatry. This has implications not only for the theoretical understanding of hypnosis, but also for its therapeutic application and will therefore be related in an important way to any teaching and training program. In a sense it is unfortunate that the induction of hypnosis is generally so simple a matter that it requires little or no technical skill or training. This, in itself, represents one of the main hazards in its utilization, since it lends itself to over-simplification and over-dramatization with a production of spectacular phenomena that are meat for the charlatan. The use of hypnosis has a recognized place in the medical armamentarium and is a useful technique in the treatment of certain illnesses when employed by qualified medical and dental personnel.

It has already been emphasized in this report that a background of psychodynamic psychology and psychiatry is essential in order to understand the phenomena of hypnosis. It is equally important to insist on the fact that the utilization of hypnotic techniques for therapeutic purposes should be re-

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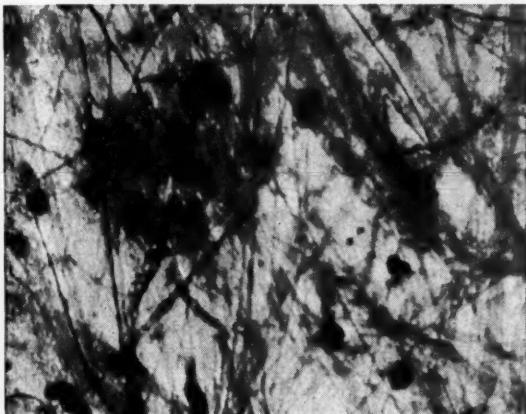
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stricted to those individuals who are qualified by background and training to fulfill all the necessary criteria that are required for a complete diagnosis of the illness which is to be treated. Hypnosis should be used on a highly selective basis by such individuals and should never become a single technique used under all circumstances by a therapist. No physician or dentist should utilize hypnosis for purposes that are not related to his particular specialty and that are beyond the range of his ordinary competence. As an example, a trained and qualified dentist might use hypnosis for hypnoanesthesia, hypnoanalgesia, or for the allaying of anxiety in relation to specific dental work. Under no circumstances would it be proper for him to use hypnosis for the treatment of neurotic difficulties of his patient. The surgeon, obstetrician, anesthesiologist, gynecologist, internist, and general practitioner may legitimately utilize these techniques within the framework of their own particular field of competence.

A great deal has been said about the hazards of hypnosis, and this is still a controversial matter. One of the members of the conference, who is in a somewhat unique position since he has been consulted professionally by many colleagues who have utilized hypnosis and has also made a survey of results, presented material which indicated that in a number of patients there were harmful results which included

the appearance of psychotic conditions and other complications. On the other hand, other consultants either personally or through correspondence indicated that they were not aware of any such harm resulting from the use of hypnosis. This is an area for further research.

II. It can be stated, therefore, that general practitioners, medical specialists, and dentists might find hypnosis valuable as a therapeutic adjunct within the specific field of their professional competence. It should be stressed that all those who use hypnosis need to be aware of the complex nature of the phenomena involved.

III. Teaching related to hypnosis should be under responsible medical or dental direction, and integrated teaching programs should include not only the techniques of induction but also the indications and limitations for its use within the specific area involved. Instruction limited to induction techniques alone should be discouraged.

IV. Certain aspects of hypnosis still remain unknown and controversial, as is true in many other areas of medicine and the psychological sciences. Therefore, active participation in high level research by members of the medical and dental professions is to be encouraged.

V. The use of hypnosis for entertainment purposes is vigorously condemned.

"Has not the tyrant another object which is that they be impoverished by payment of taxes, and thus compelled to devote themselves to their daily wants and therefore less likely to conspire against him?"

Plato



Component Medical Societies

ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.

Journal Representative

DR. ALBERT GOLDSTEIN ADDRESSES
ALLEGANY-GARRETT COUNTY
MEDICAL SOCIETY

On Wednesday, February 11, 1959, Dr. Albert E. Goldstein of Baltimore, Maryland, talked to the members of the Allegany-Garrett County Medical Society. His subject was "Hematuria."



Drs. S. M. Jacobson, Albert E. Goldstein, speaker, Dr. L. B. Ransom, President, Allegany-Garrett County Medical Society.

He emphasized the significance of blood in the urine. Patients presenting the sign of hematuria should be considered as having a serious urinary tract disease until proven otherwise. Sometimes hematuria is the only sign, while at other times the symptoms of urinary frequency, chills and fever, nausea and vomiting and loss of weight may be present.

The importance of an early examination and diagnosis may prevent serious damage. He also stressed the necessity of examining the patient in the stage of bleeding, since bleeding ceases in many instances and may not return for months.

The diagnosis can be made by the following procedures.

1. Careful histories.
2. Frequent microscopic studies of the urine.
3. Blood studies.
4. X-rays including intravenous and retrograde pyelograms, cystograms and cystoscopies.

Children may suffer from the same urinary tract conditions as adults.

He stressed objection to the use of drugs, until a diagnosis is made.

"The fire that on my bosom preys
Is lone as some volcanic isle".

—Lord Byron

BALTIMORE CITY MEDICAL SOCIETY

CONRAD ACTON, M.D.

Journal Representative

On the cold night of Friday, February 6, 1959, the Baltimore City Medical Society assembled about 30 members for a most interesting meeting. The business of the meeting was concerned with the election of new members, by tedious written ballot as usual, and the announcement that the president-elect, Dr. Hanford H. Hopkins, had submitted his resignation. This was received with considerable regret. President Samuel Whitehouse said that a special meeting would be held in the near future for the election of his successor.

President Whitehouse called on Dr. I. Ridgeway Trimble, chairman of the Program Committee, to introduce the speaker of the evening. Dr. Trimble reported that of the 1350 questionnaires sent to the members of the society in advance of the meeting, 750 had returned their answer. This was a gratifyingly high number and the data from them were included in the evening's address. Dr. Trimble characterized the speaker, Dr. George E. Miller, director of house staff education, Buffalo General Hospital, Buffalo, New York, as an internist by inclination, a researcher by occupation, and an education director by avocation.

Dr. Miller was a pleasant, personable, and witty speaker. Exemplifying all the attributes he feels are required in a teacher of medical subjects, he ingratiated himself with his audience by recalling memories of Pimlico race track and kept his audience in full contact with the development of his theme through the brief 30 minutes of his talk. His title, "Medical Education: Genesis and Exodus," was based on those biblical works. He first reminded us that in the early days of medicine, transmission of

medical art was strictly by apprenticeship, so the text from Genesis, ". . . and every living thing begat after its own kind. . ." literally applied. The informal type of education had given way in the last 200 years to greater formality deserving the title of education. So much has it changed in these 200 years, however, that it sometimes seems in the present day that only the semester *hours* spent in school determine the degree of learning, with little regard to curricular manipulation of course, context, or sequence. Teachers sternly pass foibles on "each after his own kind." At this point he showed a diagram of replies to the questionnaire concerning the relative importance of teacher *or* curriculum. The overwhelming vote was in favor of *teacher* importance exceeding that of curriculum. He noted little attention is given to the training or selection of a teacher appropriate to the subject taught. Frequently a subject is proposed and initiated with a great deal of fervor and hope, then peters out. The alibis deal with appropriateness and amount of time allotted, student interest and ability, and the like. No one considers the teacher's teaching ability or personality.

Concerned with this, he and a dozen "young Turks" initiated a seminar on "The Dynamics of Learning," which was presided over by Dr. Nathaniel P. Cantor. The results were surprising to the participants and were reported as "Adventure in Pedagogy" in the December 15, 1956 *J. A. M. A.* Revelation that ability to teach had importance in medical education shocked some New England contemporaries to a rebuttal, "Disaster in Pedagogy," in the September 1957 *New England Journal of Medicine*. Dr. Miller quoted opposing points of view from these articles throughout his talk.

At least two definite things had come to his attention after his seminar:

1) The importance of *motivation*. People learn what they *want to learn*. Others *can help us want to learn*. He quoted from a variety of education authorities, particularly Dr. Whitehead, who described the progress of education going traditionally stepwise from the sphere of romance, to the area of precision, to the era of generalization in practically any subject.

2) The axiom that *knowledge* and *learning* are different. So often people seem to be devoted to memorizing, or what was called "psittacene learning" by Idaho's Dr. William Bean. Learning is as much emotional as intellectual. From the seminar it further

developed that *learning requires freedom*: freedom to be different, to be individual, to make mistakes. Few teachers of medical education are mature enough to encourage the disagreement of their pupils or to survive it.

Following the success of the seminar, many of the participants were noted to have changed their ways of teaching and to invite students to share in the learning process. This seems to take a great deal more time on the part of the teachers and to present a conflict with research aims in some quarters.

After the seminar the group went to the Faculty of Education of the University of Buffalo, where a cooperative study of medical education was joined by groups from both faculties. Medical teachers primarily were found to be a defensive group who relied excessively on authority in their teaching: "this is the way you do it," without explanation or other reason. This study was conducted in depth and found to be significant in such factors as student background, materials and methods of instruction.

There seemed to evolve from this study in depth four basic points in the learning process: information, understanding, skills, attitudes. The significance of the *lecture* versus the *lecturer*; some lecturers tell more than the audience wants to know and some teaching aids have more than is needed for the point to be illustrated. He queried the basis of the current vogue of discredit in which the lecture method has fallen. He claimed the vogue seems to be without reasonable basis in view of the extent to which the lecture method is used by the teachers of education themselves.

The significance of tests was brought up, whether they were simply a challenge to one's ability to memorize, or to interpret. He read off a ludicrous illustration from an examination in surgery. It was intended to test one's ability to reason and decide the validity of the premises of a syllogism in accordance to the truth or falsity of the dozen or so concepts contained. Tests as such are valid only in relation to the goals at which they are aimed.

He concluded that professional teachers do have something to offer medical education. He recommended that we stop thinking that teachers are "born." They must *learn* as well. He compared the teacher to the musician, who may have been "born" but still must practise. Medical educators, he felt, should ask for help from those who can give it: pri-

marily students, who are actually the only ones who know the medical teacher at work; or colleagues, or even professionals in education. The request for assistance *must* be specific, not laudatory. Professionals in education are largely cognizant of requirements of pedagogy in the elementary, primary, and secondary school areas. They don't know the *content* of medical education, and must learn it in order to help medical educators learn how to educate. He quoted from Plato that "what is honored in a country will be cultivated there," and suggested that when due honor and recognition are given to competent medical educators, then we will have more competent medical educators.

Although the audience was small, it was select, and there was a sense of tremendous edification among those who followed this beautifully pitched talk. Coffee and doughnuts were served by the Woman's Auxiliary, and there was prolonged discussion of this very stimulating presentation.

CAROLINE COUNTY MEDICAL SOCIETY

H. R. TRAPNELL, M.D.

Journal Representative

The Caroline County Medical Society was host to a four-county meeting held at the Brick Hotel in Denton on Thursday, January 15. The other counties represented were: Talbot, Queen Anne and Kent.

The guest speaker was Dr. Nathan Needle, president of the Maryland Heart Association, who presented a talk, "The Generalist and Heart Disease". A discussion on prevention of rheumatic heart disease was led by Dr. Thurston Harrison.

FREDERICK COUNTY MEDICAL SOCIETY

LOUIS R. SCHOOLMAN, M.D.

Journal Representative

The regular January meeting was held at the Francis Scott Key on the 20th. The entire session was devoted to the consideration of a proposed new constitution and bylaws. After many deletions and

additions the constitution and bylaws were adopted unanimously.

HARFORD COUNTY MEDICAL SOCIETY

J. RALPH HORKY, M.D.

Journal Representative

The Harford County Medical Society met January 15 at 4:30 P.M. in the main dining room of the Bayou Restaurant, Havre de Grace, Md. In view of the scenic entrance of Route 40 to the Susquehanna Bridge, cocktails were privately served, thus stimulating interest in the meeting and the excellent meal that all present knew would follow. The present system has encouraged an average 80 per cent attendance and some really fine and productive activity.

Under the towering (6'4") new president, Phil Heuman, M.D., a disciplined meeting ensued. To question the authority of such a noted veteran of Old Baldy is not good taste or morally healthy. Old business was quickly disposed. Ed Loo, our vice president (5'5") is sure going to have to fill some big shoes in Phil's absence, but Secretary Randy Ross will end up with much more definite minutes.

The Baltimore City Society's resolution on hospital meeting attendance was discussed, but too few members attempted to make a decision. The resolution as presented could be confused to relegate two authorities in the matter as pointed out by Fred Hatem, M.D., our legal source of authority. We will, however, reach a definite decision before the April meeting and will so instruct our delegate, Dudley Phillips, M.D.

The most significant and progressive act of the day was the passing of a resolution condemning a few optometrists who have extended their practice into the field of ophthalmology. Specific cases and names were presented by Dr. Robert Follweiler. A copy of this resolution was sent to the State Optometry Society. The State Pharmaceutical Association was also sent a copy so they could warn local pharmacists of the impropriety and illegality of filling prescriptions by such unauthorized sources.

Thus ended our first meeting of 1959. Prospects for a disciplined and cooperative year are good.

**MONTGOMERY COUNTY MEDICAL
SOCIETY**

CHARLES FARWELL, M.D.

Journal Representative

The January dinner meeting was well attended at Brooke Manor Country Club. Merrill M. Cross, M.D. substituted for the scheduled scientific lecture a cogent talk on the need and planning for organized medical efforts in community emergency. The medical doctors of our county are agreed on the wisdom of being prepared to work together for emergency medical service.

Our *Medical Bulletin* is becoming more informative and interesting with each issue. Each month a section is devoted to Principles of Medical Ethics, which helps increase understanding and courtesy. A brief biographic sketch of some of our distinguished members is a welcome highlight added to recent *Bulletins*.

William T. Joyce, M.D. outgoing president received a plaque for his 1958 leadership from Dr. Merrill M. Cross, past president, and from president-elect for 1959, Henry P. Laughlin, M.D.

The Woman's Auxiliary meeting in January was graced by the presence of the president of the Woman's Auxiliary to the Maryland State Medical Society, Mrs. E. Roderick Shipley.

Dr. Henry P. Laughlin showed the film taken during his round-the-world trip this past summer.

Edward C. McGarry, M.D. was elected secretary-treasurer of the Maryland Society of Pathologists and is also a member of the Board of Directors, Montgomery County Chapter and State of Maryland Division of the American Cancer Society.

Elmer W. Lorenz, M.D. passed the American Board of Otolaryngology.

Several popular medical talks were given by volunteers of our Speaker's Bureau; two that included films were Charles J. Savorese Jr., M.D. on mouth to mouth resuscitation and Avron Maser, M.D. on breast self-examination.

The uses and abuses of a relative value scale for medical fees are being studied thoroughly and carefully.

**ST. MARY'S COUNTY MEDICAL
SOCIETY**

DAVID L. MOSSMAN, M.D.

Journal Representative

The election meeting of the St. Mary's County Medical Society was held on January 26, 1959 at Bailey's Restaurant in Leonardtown, Md. Eight out of 13 members were present and, according to the custom, each officer moved up a notch, with the present president going out of office completely.

An active campaign to encourage polio vaccination in the county was adopted with the approval of press releases and the agreement of the members to push immunization to their patients.

A lengthy discussion as to how to give complete physical examination to medical care patients needing evaluation for disability was not fruitful. The problem remained as to how to do justice to this examination within the limits of a busy practice already crowded with welfare patients.

Dr. P. J. Bean, a long active general practitioner, was recently recognized for his long devotion to his patients by being awarded the Order of St. Gregory by the Roman Catholic Church. This distinction was put into the minutes of this meeting.

Dr. Abdusamed Samadi, formerly of Washington, D.C., was welcomed as a new member of the Society. He is a board eligible surgeon who has been trained in cardiac and thoracic as well as general surgery.

Another physician also came to live in the county during the last year. She is the wife of Michael Barbarich, M.D., the chief of surgery at the County Hospital, whose exploits in returning her from the communist bloc were publicized in the papers last year. A pediatrician, Dr. Emma Barbarich has talked to the Society previously about the Soviet method of practicing medicine.

The combined monthly hospital staff and medical society meeting was held at the St. Mary's County Hospital Doctors Library in Leonardtown on February 11, 1959. It was presided over by Dr. William Patrick, chief of staff and president of the County Medical Society. There was 100 per cent attendance.

Following the recommendation of Dr. John Whitridge, Jr. of the State Health Department, who gave a talk on Perinatal Mortality in December, the major part of this meeting was utilized in a round table discussion of the January 1959 perinatal mortalities and the relationship, ideal and actual, between the County Health Department Prenatal Clinic and the private physician. A committee was

appointed to effect liaison between the Society and the deputy health officer in this regard.

The policy of routine chest X-rays for all hospital admissions was reaffirmed by unanimous vote. A resolution from the Baltimore City Medical Society for a change in hospital accreditation with regard to attendance at staff meetings was approved without discussion.

JUNE						
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June 8-12 attending the 108th
annual meeting - American
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CIVIL DEFENSE

I. RIDGEWAY TRIMBLE, M.D.

Chairman, Committee on National Emergency Medical Service

EDITOR

Because of the huge increase in physical force and radiation of the hydrogen bomb the collection and care of casualties has had to be greatly modified. Plans made even a few years ago are now out of date and are constantly being revised. At the present time there are 202 casualty clearing stations organized in Maryland. It is realized that many of these will become inoperable in the event of an attack on Baltimore. It may be that we will have to give first priority to those stations situated on highways 12 miles or further from the center of the city.

I have asked Dr. John M. Welch, Medical Officer, Maryland Civil Defense Agency, to make some comments under the subject, "Care of Casualties Through the Various Lines of Evacuation," dated January 28, 1959 which follows:

CARE OF CASUALTIES THROUGH THE VARIOUS LINES OF EVACUATION

The kind of casualty care contemplated under the Civil Defense program would involve a disaster having a large community impact and due to a force causing conceivably large numbers of casualties strewn over an extended area of terrain.

The State Civil Defense Statute ranks a Civil Defense occurrence as one of "unprecedented size and destructiveness," and specifies in its plan the Casualty Clearing Station as the field element for the medical organization. The need for Casualty Clearing Stations, as one may know from military experience, presupposes the need for field clearance of casualties who are brought to a central point at which medical talent can be conserved and devoted to the sorting and lifesaving treatment of a collected number of the injured.

The Casualty Clearing Station of the State is organized with this mission in view. The section that furnishes first aid and clears the field of wounded through use of litter bearers (and vehicles where possible) is the field section of the unit. The station section, having normally two physicians and three nurses, as well as paramedical and trained lay personnel up to 50 in number, is the station section. This latter section, forming the station proper, sorts the wounded and is prepared to relieve pain, arrest hemorrhage, administer serum albumin and plasma expanders or group O whole blood, with equipment also to remove foreign bodies, establish airways, dress wounds, immobilize fractures and administer antibiotics and other medications.

The field section of the Casualty Clearing Station is made up of trained first aid personnel and litter bearers. They administer emergency aid to casualties at the place of contact in the field or after release from wreckage by Civil Defense rescue squads. It is

normal practice for the field personnel to gather groups of non-walking wounded at collecting points where relief measures can be continued until final movement to the Casualty Clearing Station. Such collecting points are called First Aid Stations in the State terminology, and would normally number three to five for each Casualty Clearing Station. Movement from these aid stations to the Casualty Clearing Station is made by further hand carriage, or preferably, by vehicles, as soon as clearance of the terrain renders this possible.

Most physicians have had military experience or instruction and will understand the employment of the military counterpart of the Casualty Clearing Station. The State's unit would be used in like manner in any widespread natural disaster that would warrant its employment. There is possible, however, a disaster greater than a large natural disaster which would definitely demand variations from the usage that military experience has taught.

The Civil Defense disaster greatest in its degree of "unprecedented size and destructiveness" would be that caused by a nuclear weapon of megaton range. If we take the position that the Federal Government urges upon us, we will direct our preparation against the worst that might happen—and this is it. The theory is that while it would be relatively simple to take in stride a calamity less than the one planned for, it would be extremely difficult to cope with one greater than planned for, after the lightning had already struck. The Federal authorities now urge us to gear our maximum disaster preparations to the damage that would result from a 20-megaton hydrogen bomb of surface burst.

In such a catastrophe we would have to alter some

of our current views regarding the ideals of emergency medical care. These changed concepts would more strikingly affect the care at forward treatment stations but would also affect patient care in the hospitals to the rear of them.

In the matter of its effect upon the type of casualty: we could expect a large preponderance of serious burn cases, radiation sickness of varying degrees, and widespread effects of mental trauma, besides, of course, large numbers of infected soft tissue injuries and fractures.

In terms of the maximum disaster cited, it could be expected that individuals would not survive within ten miles out from the center of the burst, unless they were to have the advantage of sufficient shelter from the great intensities of heat and radiation. This would apply to casualties in this area whose earliest aid would consist in self help, neighbor help and family help. Potential blast and thermal casualty survivors could be expected in the area to the rear of this ten-mile zone, but these, too, would not survive unless they had adequate protection from radiation during the first several hours.

It is to be understood also that a Casualty Clearing Station could not occupy a surviving building at a distance of 11 or 12 miles from the center of burst on a continued basis until the radiation in that area had decreased to at least ten roentgens per hour. This would certainly require several hours. If aid men and litter bearers were to operate further forward they would have to be used at the outset in relays under calculated periods of radiation exposure. These requirements also apply to the operation of hospitals further to the rear, although radiation intensities could be expected to be somewhat less than at points further forward.

Since exposure to the damaging force cited would be part of an enemy attack, it could be definitely expected that the attempt would be an all-out one, country-wide, in order to drive for a decision before effective retaliation. Forced upon us, then, would be the criterion of national survival and an outlook aligned toward the total surviving population. This would have to be registered in the care administered at every medical station and hospital. Casualties

having doubtful chances, whose care would require many medical man-hours and precious supplies, would have to give way to those who could be put into shape to do a job with promptness and economy of means. Children and women of childbearing age would also receive preferential care.

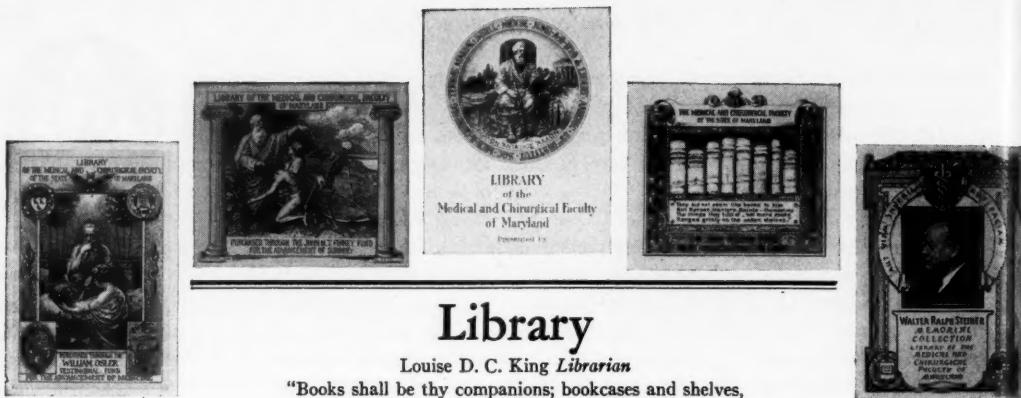
Into this picture would also come the consideration that our medical supply and equipment industry is almost 100 per cent vulnerable to such an attack, and the surviving population, vital in rebuilding the nation, would have to depend very largely and for an extended period on the same stockpiled medical supplies that are drawn upon for the care of casualties. This, of course, would dictate the strictest austerity in expenditure of supplies.

Standardization must be expected in building up medical stockpiles. In our forward medical stations and emergency hospitals we must expect multi-purpose use of a majority of items, as, for instance: a single type of needle holder, a cutting and non-cutting surgical needle, a universal suture if possible, a minimum of hemostats, ribbon retractors instead of specialized retractors, basic minimum survival drugs, etc.

Definitive surgery would be reserved for emergency hospitals and surviving permanent hospitals. Emergency hospitals would continue in operation for perhaps a year. They would take part in caring for the ills of the surviving population as well as caring for disaster casualties. Some patients, of course, would have to be sent to specialized hospitals set up in central locations. One of these specialized hospital centers would service a good number of general Civil Defense emergency hospitals.

The Office of Civil and Defense Mobilization is in process of developing six packaged units to equip existing medical facilities to perform specialized surgery. These units are: dental, gastrointestinal, genitourinary, neurological, cardio-thoracic, and eye, ear, nose and throat.

Also in process is the development of equipment for Emergency Treatment Stations. These stations would have the same function as the present Casualty Clearing Stations but would be more comprehensive in size and technical capacity. It is expected that they will eventually supersede the latter unit.



Library

Louise D. C. King *Librarian*

"Books shall be thy companions; bookcases and shelves,
thy pleasure-nooks and gardens." *Ibn Tibbon*

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Annual Meeting in April, 1959

Abramson, David	Road to emotional maturity. Englewood Cliffs, 1958	Boas, Marie	Robert Boyle and 17th century chemistry. Bost., 1958
Aegerter, Ernest	Orthopedic diseases. Phil., 1958	Bowden, R. E. M.	Peripheral nerve injuries. Lond., 1958
Alexander, Leo	Objective approaches to treatment in psychiatry. Springfield, 1958	Boyd, William	Pathology for the physician. 6th ed. Phil., 1958
Allen, J. H., ed.	Strabismus: ophthalmic symposium II. Springfield, 1958	Braestrup, C. B.	Radiation protection. Springfield, 1958
Alston, J. M.	Leptospirosis in man and animals. Balt., 1958	Brondsted, H. V.	The atomic age and our biological future. N. Y., 1958
American College of Radiology	Practical manual on the medical and dental use of X-rays with control of radiation hazards. Chic., 1958	Brown, J. B.	Skin grafting. 3d ed. Phil., 1958
Anderson, V. E.	Variables related to human breast cancer. Minneapolis, 1958	Calder, Ritchie	Medicine and man. N. Y., 1958
Archer, H. W.	Manual of dental anesthesia. 2d ed. Phil., 1958	Caderone, M. S., ed.	Abortion in the U. S. N. Y., 1958
Bailey, F. R.	Textbook of histology, rev. by W. M. Copenhaver. Balt., 1958	Carter, Richard	The doctor business. N. Y., 1958
Baldwin, Maitland	Temporal lobe epilepsy; a colloquim. Springfield, 1958	Chamberlain, Beulah	Self-destruction. A study of the suicidal impulse. Springfield, 1958
Bartley, S. H.	Principles of perception. N. Y., 1958	Chao, Dora Hsi-Chih	Convulsive disorders of children. Phil., 1958
Beaudette, F. R., ed.	Progress in psittacosis research and control. New Brunswick, 1958	Code, C. F.	Atlas of esophageal motility in health and disease. Springfield, 1958
Belding, D. L.	Basic clinical parasitology. N. Y., 1958	Cope, Zachary	Early diagnosis of the acute abdomen. 11th ed., N. Y., 1957
Benedict, E. B.	The esophagus: medical and surgical management. Bost., 1958	Crohn, B. B.	Regional ileitis. 2d ed. N. Y., 1958
Bernreiter, Michael	Electrocardiography. Phil., 1958	Darzins, Egons	Bacteriology of tuberculosis. Minneapolis, 1958
Bishop, W. J.	Bibliography of International Congresses of Medical Sciences. Springfield, 1958	Davison, W. C.	Compleat pediatrician. Durham, 1958
Blahd, W. H.	Practice of nuclear medicine. Springfield, 1958	Deichmann, W. B.	Signs, symptoms and treatment of certain acute intoxications. Springfield, 1958
Blake, J. B.	Benjamin Waterhouse and the introduction of vaccination. Phil., 1957	Dow, R. S.	Physiology and pathology of the cerebellum. Minneapolis, 1958
Bloomfield, A. L.	Bibliography of internal medicine: communicable diseases. Chic., 1958	Dubos, R. J., ed.	Bacterial and mycotic infections of man. Phil., 1958
		DuBruhl, E. L.	Evolution of the speech apparatus. Springfield, 1958
		Duffy, John, ed.	Rudolph Matas History of medicine in La. v. 1, 1958 New Orleans
		Duke-Elder, Sir S.	System of ophthalmology v. 1, 1958 St. Louis

Dunham, Arthur Community welfare organization. 1958

Fiese, M. J. Coccidioidomycosis. Springfield, 1958

Freeman, Lucy So you want to be psycho-analyzed. N. Y., 1958

Follis, R. H. Deficiency disease. Springfield, 1958

Francis, John Tuberculosis in animals and man. Balt., 1958

Gallagher, J. R. Emotional problems of adolescents. N. Y., 1958

Gant, W. H., ed. Physiological bases of psychiatry. Springfield, 1958

Gardner, Ernest Fundamentals of neurology. 3d ed. Phil., 1958

Gardner, W. D. Diagnostic anatomy. St. Louis, 1958

Gibbs, F. A. Epilepsy handbook. Springfield, 1958

Gifford, E. S. Evil eye. N. Y., 1958

Glynn, J. H. Cortisone therapy. N. Y., 1958

Gray, Henry Anatomy. 32d ed. Phil., 1958

Greenfield, J. G. Neuropathology. Balt., 1958

Gregg, Alan For future doctors. Chic., 1957

Hamm, F. C. Urology in general practice. Phil., 1958

Harrison, T. R., ed. Principles of internal medicine. 3d ed. N. Y., 1958

Hartman, F. W. Hepatitis frontiers: Henry Ford Hospital International symposium. Bost., 1957

Hebb, D. O. Textbook of psychology. Phil., 1958

Houts, N. comp. Courtroom medicine. Springfield, 1958

Ingle, D. J. Principles of research in biology and medicine. Phil., 1958

Interdepartmental Com. on Med. Training Aids Film reference guide for medicine and allied sciences. Wash., 1958

Jackson, Ruth Cervical syndrome. Springfield, 1958

Jaffe, H. L. Tumors and tumorous conditions of the bones and joints. Phil., 1958

James, J. D. Practical blood transfusion. Springfield, 1958

Jordan, H. H. Hemophilic arthropathies. Springfield, 1958

Katzenbogen, S. Analyzing psychotherapy. N. Y., 1958

Keevil, J. J. Medicine and the Navy, 1200-1900 v. 1, 2 Balt., 1958

Keith, J. D. Heart disease in infancy and childhood. N. Y., 1958

Kritchevsky, David Cholesterol. N. Y., 1958

Krugman, Saul Infectious diseases of children. St. Louis, 1958

Landy, Chester Full dentures. St. Louis, 1958

Langley, L. L. Physiology of man. N. Y., 1958

Lassek, A. M. Human dissection: its drama and struggle. Springfield, 1958

Lee, R. I. A doctor speaks his mind. Bost., 1958

Lewis, G. M. Introduction to medical mycology. 4th ed. Chic., 1958

Licht, Sidney Therapeutic exercise. New Haven, 1958

Liebman, Samuel, ed. Emotional problems of childhood. Phil., 1958

Liebowitz Bleeding esophageal varices and portal hypertension. Springfield, 1958

Ling, T. M., ed. Rehabilitation after illness and accident. Balt., 1958

Lown, Bernard Atrial arrhythmias digitalis and potassium. N. Y., 1958

Lundein, E. C. Care of the premature infant. Phil., 1958

MacNeal, P. S. Management of the patient with headache. Phil., 1957

Maimonides Preservation of youth, tr. by H. L. Gordon. N. Y., 1958

Monrad-Krohn Disaster procedure manual. Bost., 1958

Martinez Theory of psychoanalytic technique. N. Y., 1958

Menninger Clinical examination of the nervous system. N. Y., 1958

Montagna, Wm. Biology of hair. N. Y., 1958

Muercke, R. C. Lupus nephritis. Balt., 1957

Neuman, W. F. Chemical dynamics of bone material. Chic., 1958

Osserman, K. E. Myasthenia gravis. N. Y., 1958

Paschkis, K. E. Clinical endocrinology. 2d ed. N. Y., 1958

Paul, J. R. Clinical epidemiology. Chic., 1958

Penfield, Wilder Excitable cortex in conscious man. Springfield, 1958

Pfeffer, A. Z. Alcoholism. N. Y., 1958

Porta, Gian B. Natural magic. N. Y., 1957

Race, R. R. Blood groups in man. Springfield, 1958

Ravin, Abe Auscultation of the heart. Chic., 1958

Reiss, Max Psycho-endocrinology. N. Y., 1958

Riseman, J. E. F. Electrocardiogram clinics. N. Y., 1958

Roberts, K. E. Electrolyte changes in surgery. Springfield, 1958

Roberts Difficult diagnosis. Phil., 1958

Russ, J. D. Cerebral palsy. Springfield, 1958

Sakel, Manfred Epilepsy. N. Y., 1958

Saphir, Otto Autopsy diagnoses and technic. 4th ed. N. Y., 1958

Savitsch, Eugene de Homosexuality, transvestism and change of sex. Springfield, 1958

Shafer, Hine, Levy Oral pathology. Phil., 1958

Sherlock, Sheila Diseases of the liver and biliary system. 2d ed. Springfield, 1958

Snyder, C. R. Alcohol and the Jews. New Haven, 1958

Speer, Frederic Management of childhood asthma. Springfield, 1958

Steel, H. H. Staphylococcal hospital infections. Phil., 1958

Stuart-Harris, C. H. Chronic bronchitis. Balt., 1957

Swenson, Orvar Pediatric surgery. N. Y., 1958

Thorek, Philip Illustrated preoperative and post-operative care. Phil., 1958

Verney, R. E. The student life. Balt., 1958

Waters, R. M. Selected scientific papers and addresses. 1958

(Continued on page 168)



Maryland SOCIETY OF PATHOLOGISTS INC.

LOUIS B. THOMAS, M.D., President

EDWARD C. McGARRY, M.D., Secretary
Suburban Hospital, Bethesda, Md.



PERMISSION FOR AUTOPSY

Postmortem examination is truly the one way by which the dead may teach the living. But to perform an autopsy specific written permission must be obtained.

The law in Maryland regarding consent for autopsy is clearly stated as Section 147A of Article 73 of the Annotated Code of Maryland:

"Written or telegraphic consent for a Doctor of Medicine to conduct a postmortem examination of the body of a deceased person shall be deemed sufficient when given by whichever one of the following assumes custody of the body for purposes of burial: father, mother, husband, wife, child, guardian, next of kin, or in absence of any of the foregoing, a person who assumes the duty of legal disposal of the body. If two or more of such persons assume custody of the body, consent of one of them shall be deemed sufficient."

Telephonic or other verbal permission for autopsy is not legally acceptable. If no relative claims the body, legal permission for the autopsy is obtainable from the person assuming responsibility for burial.

Which individual has legal control over a body when several next of kin lay claim to it? This question is answered by Article 93 of the Annotated Code of Maryland which covers testamentary law. Sections 130-146 of this article spell out the order of inheritance of property of persons dying intestate. The order of inheritance is as follows: Surviving husband or widow, children (there being no choice among the children who are of age), grandchildren and their descendants, parents, siblings, descendants of siblings, all collateral relations to the fifth degree with no distinction between the whole and half bloods, and finally grandparents. Every person dies intestate insofar as his mortal remains are concerned, since it is commonly accepted that an individual cannot determine the manner of disposal of his own body.

No request for an autopsy permission should be sought on cases referred to the Medical Examiner.

Library (Continued from page 167)

Wechsler, David	Measurement and appraisal of adult intelligence. Balt., 1958	Woods, G. E.	Cerebral palsy in childhood. Balt., 1958
Wild, J. B.	Fundamentals in cardiology. Springfield, 1958	Young, C. B.	Transportation of the injured. Springfield, 1958
Wolf, A. V.	Thirst: physiology of the urge to drink. Springfield, 1958		
Wolff, H. G.	Pain. Springfield, 1958		

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The

Heart Page

Gordon Walker, M.D. - Coeditors - Robert Singleton, M.D.

A SERVICE OF

THE HEART ASSOCIATION OF MARYLAND

BACTERIAL ENDOCARDITIS

FRED R. McCRUMB, JR., M.D.*

During the past decade, a vast experience in the therapy of endocarditis has been accumulated. Numerous studies have led to the conclusion that penicillin, with or without streptomycin, should be employed to the exclusion of other antibiotics in all cases of streptococcal endocarditis, and that when proper therapeutic regimens are followed, a cure rate approaching 90 per cent can be expected. Response to therapy will be influenced by rapidity of diagnosis and prompt identification of the causative organism, as patients receiving adequate therapy early in the disease enjoy the best prognosis. The general practitioner should be suspicious of fever for which there is no obvious cause in patients with congenital or valvular heart disease since the early diagnosis of endocarditis must inevitably be the responsibility of the family doctor.

Bacterial endocarditis is characterized by fever, heart murmur, embolic phenomena, splenomegaly, leukocytosis and bacteremia. Since most patients have a murmur and fever, these two findings alone are sufficient evidence to begin therapy pending the results of blood cultures. The protean manifestations of endocarditis are usually the result of embolization of various organs. When emboli lodge in the skin, resultant petechiae strengthen the diagnosis. However, embolization of the brain may produce the presenting syndrome and suggest a disease process far removed from the heart. Similarly, splenic infarction producing upper abdominal pain may suggest an acute surgical problem. Renal embolization frequently results in microscopic hematuria, another feature of bacterial endocarditis. Other embolic phenomena include Osler's nodes, mycotic aneurysm and occlusion of major arteries as in the extremities.

Changing heart murmur, an oft quoted sign of differential diagnostic value, is usually not encountered except when the aortic valve is severely involved or the process is rapidly progressive.

Laboratory studies may reveal leukocytosis, and frequently there is a moderate degree of anemia. Hematuria, with or without proteinuria, is common. There are no tests of specific diagnostic value other than isolation of the causative organism from the blood. This procedure assumes a position of importance above all others, and great effort should be made to obtain several cultures before antibiotics have been administered. Three to five blood cultures at hourly intervals will usually suffice and, in many instances, all cultures obtained will yield the causative organism.

Streptococci account for 90 per cent of all cases of endocarditis. It is of the utmost importance to characterize the offending streptococcus as the therapeutic regimen for enterococcal infections differs greatly from the treatment of endocarditis caused by viridans streptococci. Viridans streptococci, normal inhabitants of the upper respiratory tract, are quite sensitive to penicillin (0.02 to 0.1 units/ml.). Enterococci or group D streptococci inhabit the gastrointestinal and genitourinary tract and are relatively resistant to penicillin (1.5 to 25 units/ml. or greater). These organisms are killed by the synergistic action of penicillin and streptomycin in combination, and therapy of endocarditis caused by enterococci must be based on this concept. For practical purposes, a penicillin sensitivity test will serve to differentiate streptococci of the viridans group from enterococci and provide vital information needed by the clinician.

Several therapeutic regimens are available for viridans streptococcal endocarditis. Penicillin administered intramuscularly at the rate of 3.0 million units daily for a period of 28 days will result in bacteriologic cures in at least 90 per cent of cases.

* Director, Section of Infectious Diseases, University of Maryland School of Medicine.

There is a growing body of evidence that the course of therapy can be reduced to 15 days if streptomycin is given concomitantly at the rate of 2.0 gms. daily by the intramuscular route. Oral penicillin can be substituted for parenterally administered antibiotic if comparable tissue concentrations are achieved. For this purpose, phenoxyethyl penicillin is probably the most useful.

Enterococcal endocarditis must be treated with a combined penicillin-streptomycin regimen for a period of six weeks. It is generally agreed that ten million units of penicillin and 2.0 gms. of streptomycin should be given parenterally for the entire

period if it is tolerated. When ototoxicity complicates therapy, streptomycin dosage may be reduced to 1.0 gram daily. Larger amounts of penicillin may be required if response to therapy is not apparent.

Endocarditis caused by other organisms is frequently more fulminant and is generally referred to as acute endocarditis. The common offenders are pneumococci, staphylococci and coliform organisms. Therapy for these diseases is based on established drugs of choice or results of in-vitro sensitivity tests. Antibiotics effective in-vitro are frequently administered too late to favorably alter the course of acute endocarditis.

POSTGRADUATE STUDY IN OTOLARYNGOLOGY

The Department of Otolaryngology, University of Illinois College of Medicine, announces two special postgraduate courses to be offered in the fall of 1959:

ANNUAL OTOLARYNGOLOGIC ASSEMBLY

The Assembly will be conducted September 18 through September 26, 1959, and will consist of a series of lectures and panels concerning advancements in otolaryngology. Some of the sessions will be devoted to surgical anatomy of the head and neck and histopathology of the ear, nose and throat. Guest lecturers will participate in an entire day's program reviewing the latest advances and principles of temporal bone surgery.

Chairmen of the Assembly are Maurice F. Snitman, M.D., and Emanuel M. Skolnik, M.D.

COURSE IN LARYNGOLOGY AND BRONCHOESOPHAGOLOGY

The course in laryngology and bronchoesophagology, under the chairmanship of Paul H. Holinger, M.D., is scheduled November 9 through November 21, 1959.

Interested physicians should write direct to the Department of Otolaryngology, 1853 West Polk Street, Chicago 12, Illinois.

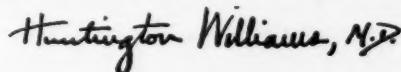
Health Department

BALTIMORE CITY HEALTH DEPARTMENT

The Organization Chart Is Again Revised

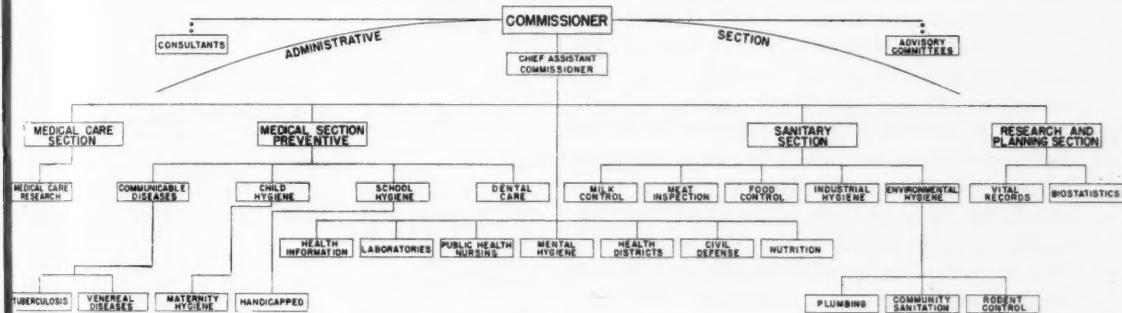
Since July, 1951 when an Organization Chart of the Baltimore City Health Department was published in *Baltimore Health News*, a number of changes in the departmental unit structure have resulted in the latest revision of the chart which is here shown. The work of the Bureau of Communicable Diseases

has been expanded to include tuberculosis control and venereal disease control, and new units have been established in the fields of mental hygiene, medical care research and the care of handicapped persons. Also, the Statistical Section has been renamed the Section on Research and Planning.



Commissioner of Health

ORGANIZATION CHART BALTIMORE CITY HEALTH DEPARTMENT



FEDERAL NEUROPATHOLOGY TRAINING GRANT AWARDED TO UNIVERSITY OF MARYLAND SCHOOL OF MEDICINE

A postgraduate training program in Neuropathology has recently been established in the Division of Neuropathology at the University of Maryland School of Medicine in Baltimore. Aided by a grant from the National Institute of Neurological Diseases and Blindness, the program is designed particularly for Board-certified pathologists or those eligible for certification who plan an academic career and who desire specialty training in neuropathology. In addition to the neuropathologic training, a two year progressive program includes instruction in the basic sciences as applied to neuropathology and some clinical correlative experience. Inquiries should be addressed to John A. Wagner, M.D., University of Maryland School of Medicine, Baltimore 1, Maryland.



MARYLAND TUBERCULOSIS ASSOCIATION

Christmas Seal Agency for State of Maryland

900 ST. PAUL STREET

BALTIMORE 2, MARYLAND

TUBERCULOSIS DIVISION

Baltimore City Hospitals

EDMUND G. BEACHAM, M.D.*

Baltimore City Hospitals has a 300 bed division which provides hospitalization for tuberculous residents of Baltimore. During 1958 there were 352 admissions with 41 deaths and 302 regular discharges including 89 irregular discharges (against medical advice). These statistics represent the largest hospital activity in over 10 years (Table I).

Of the 308 cases of pulmonary tuberculosis in 1958 there were about 10 per cent minimal, 45 per cent moderately advanced, and 45 per cent far advanced. Almost 25 per cent had been admitted to this or other tuberculosis hospitals in the past. About 80 per cent were direct admissions, 20 per cent being transferred from other divisions of the hospital, chiefly the acute medical service. Ten per cent were over 60 years of age on admission, 28 per cent over 50 years and 52 per cent over 40 years. There were about 75 per cent non-white admissions. The average hospital stay for discharged patients was about ten months.

One of the principal advantages of location of a tuberculosis hospital near a general hospital is revealed in the number of consultations. All patients were seen on admission by the dental staff. Among discharged patients there were 207 ear, nose and throat consultations, mostly bronchoscopies; all female patients have a routine gynecological examination; there were 178 surgical consultations, 80 eye consultations and 48 psychiatric evaluations and 45 neurological examinations. Physical therapy service was given to 25 patients and dermatological consultation to 22 patients.

Although most of the admissions have advanced pulmonary tuberculosis, many have other tuberculosis complications or associated diseases. During 1958 there were 11 cases of diabetes, seven pregnancies,

ten patients with miliary or meningeal tuberculosis, and 21 with a complicating pleural effusion. Only two cases of bronchogenic carcinoma were noted and only one pneumoconiosis. An evaluation of complications noted on admission from 1952-58 demonstrates the need for wide diagnostic and therapeutic services (Table II).

During the last four years and about 1200 admissions, there have been 3.5 per cent diabetics, 2 per cent pregnancies, 4.5 per cent with pleural effusion, 2.5 per cent having miliary or meningeal tuberculosis, and 1.5 per cent bone tuberculosis.

TABLE I

Year	Admissions	Deaths	Other Discharges	Regular Discharges	Irregular Discharges	Per Cent
1949	184	80	142	107	35	25
1950	203	84	118	104	14	12
1951	190	60	124	99	25	20
1952	145	37	119	86	33	28
1953	213	33	148	120	28	19
1954	291	32	203	148	55	27
1955	249	29	238	195	43	18
1956	282	52	251	183	68	27
1957	308	48	266	186	80	30
1958	352	41	302	213	89	29

TABLE II

Complicating Condition	1952	1953	1954	1955	1956	1957	1958	Total
Diabetes Mellitus...	3	—	1	7	10	15	11	47
Pregnancy.....	2	—	—	3	6	8	7	26
Pneumoconiosis.....	1	—	—	—	2	1	1	5
Sarcoidosis/Tbc.....	—	—	1	—	3	4	6	14
Bronchogenic CA...	2	1	—	2	1	—	2	8
Tbc. Pleural Effusion.....	3	3	3	5	13	13	21	62
Lymph Node Tbc.....	—	1	—	1	2	3	7	14
Tbc. Peritonitis.....	—	1	—	—	3	5	5	14
Tbc. Pericarditis.....	—	3	1	1	2	1	—	8
Bone Tbc.....	—	—	4	—	6	6	6	22
Pelvic Tbc.....	—	—	—	—	3	6	—	9
G. U. Tbc.....	—	1	—	5	6	2	2	16
Miliary/Meningitis.	4	5	13	4	10	6	10	52

* Chief, Tuberculosis Division, Baltimore City Hospitals.

About 15 per cent of patients have pulmonary surgery, mostly lobectomies and segmental resections with few pneumonectomies. Primary thoracoplasty is rare though thoracoplasty is used frequently following resection when the remaining lung tissue leaves residual space after expansion.

Bedrest is still a fundamental treatment and in most cases strict bedrest is offered for about four months, then bathroom privileges until full ambulation at six months. Following surgery we now begin bathroom privileges within two weeks post-operatively and allow full ambulation at three months.

Drug regimens vary widely with use of Streptomycin, Sodium Para-aminosalicylic Acid, Isoniazid, Pyrazinamide, Viomycin, Cycloserine, and Kana-

mycin. Most patients receive Isoniazid 3-5 mgm./Kg. body weight daily in two doses with Sodium P.A.S. 12 Gm. daily in three doses with meals. Triple drug therapy, SM, INH and PAS are used in miliary or meningeal tuberculosis, in bone or renal tuberculosis, and in some seriously ill patients. Change in therapy is dictated by clinical and X-ray course guided by laboratory investigation of sputum and development of strains of tubercle bacilli resistant to drugs. At discharge most patients are sent to their physicians or Baltimore City Health Department Chest Clinics to continue drug therapy for a prolonged period.

It is indeed encouraging to compare the 1946 data of 330 admissions with 165 deaths and only 80 regular discharges with 352 admissions in 1958, only 41 deaths and 213 patients given regular discharges.

FIFTH ANNUAL SURGERY, RADIOLOGY, PATHOLOGY SYMPOSIUM

THYROID DISEASES

Diagnosis and Treatment

Friday, May 8 and Saturday, May 9, 1959

Fifth in a series formerly held in February

Office of Postgraduate Education, University of Oklahoma Medical Center

With

Oklahoma Association of Pathologists

Oklahoma State Radiological Society

Oklahoma Chapter of the American College of Surgeons

Write: Office of Postgraduate Education
University of Oklahoma Medical Center
801 Northeast 13th Street
Oklahoma City 4, Oklahoma



THE MARYLAND ACADEMY OF GENERAL PRACTICE

(A constituent chapter of the American Academy of General Practice)

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ART VERSUS SCIENCE

"OPINION IS LIKE A PENDULUM AND OBEYS THE SAME LAWS"

It must have occurred to many physicians to wonder why our profession is faced with the prospect of being taken over by our government. Does it indicate that we have failed to provide adequately for the health needs of the population? Statistics deny this. The health record of this country is among the best. Is it because the cost of medical care has risen beyond the ability of the general population to purchase it? Compared to other increases in the cost of living, this is not so. I believe we are faced with federal control of medicine because there has been an evolutionary change in the average citizen's personal sense of values during the past generation. As people have become more materialistic, medicine has come to be looked upon as a commodity rather than a service. Now medical care has taken a place beside material items on the market, and many groups would like to shift the responsibility for providing this care from the patient and doctor to the federal government. Changing attitudes and demeanor on the part of the profession itself may have encouraged this concept.

History tells us that for centuries medicine was an art. At no time before the Renaissance were conditions favorable for the development of medicine as a science. From the sixteenth to the eighteenth centuries discoveries by Vesalius, Harvey, Leeuwenhoek and Lavoisier increased knowledge of biology, physics, chemistry and physiology. From the middle of the nineteenth century progress was rapid. The contributions of Lister, Pasteur, Ehrlich, Virchow, Koch, Roentgen and Madam Curie are well known. The astounding progress in the past 50 years made medicine a science. Each patient provides a scientific problem approached in a methodical manner. The physician observes, formulates a diagnosis, confirms it by laboratory tests or mechanical aids and treats

with decisive tools. Medical knowledge has increased to such a degree that no one person can assimilate all and the age of specialization is upon us. The pendulum has swung far.

To remedy this situation a concentrated effort must be made to achieve a balance. Medicine should be a careful blending of the two basic elements—art and science.

The importance of this fact is evident where one recognizes that more than a third of the patients seeking medical aid today have functional illness that requires the application of more art than science. Specific remedies are not available for more than a small percentage of all illnesses met within the average general practice. It seems ironic that as specific knowledge advances at a rapid rate our appreciation of the very basic art of medicine is diminishing to an alarming degree.

The general practitioner holds no monopoly in the practice of the *art* of medicine but by virtue of his position as family doctor he is often at an advantage in this area. It is often the recognition of the importance of the art that prompts a man to choose *general practice*.

For further information on the Maryland Academy of General Practice write to Charles Paul Crimy, M.D. Secretary, 2722 Monument St., Baltimore, Md.

The next area scientific meeting of the Maryland Academy will be held at the Statler Hilton Hotel in Washington, D.C. on May 7.

PROGRAM

1. Fluid and Electrolyte Balance
Michael J. Lepore, M.D.
Columbia University
New York, New York
2. A Practical Approach to Gynecologic Problems
Isadore Dyer, M.D.
Tulane University
New Orleans, Louisiana

3. Collagen Disease, the Overlooked Diagnosis
Edmund L. DuBois, M.D.
U.C.L.A., Los Angeles,
California
4. Infrequently Seen Diseases of Childhood
Carl C. Fischer, M.D.
Hahnemann Medical School
Philadelphia, Pennsylvania
5. Broad Spectrum Antibiotics after 10 Years
Harry F. Dowling, M.D.
University of Illinois
Urbana, Illinois
6. What Medical Science is Doing about the Aging
Edward L. Bortz, M.D.
Lankenau Hospital
Philadelphia, Pennsylvania

ANNUAL

APRIL 15, 16, 17

THE ALCAZAR
Baltimore, Md.

MEETING



Woman's Auxiliary Medical and Chirurgical Faculty



MRS. DAVID S. CLAYMAN, *Auxiliary Editor*

BOARD OF THE WOMAN'S AUXILIARY TO THE MEDICAL AND
CHIRURGICAL FACULTY
1958-59



Left to right: Seated—Mrs. Albert Goldstein, Baltimore; Mrs. E. Paul Knotts, Caroline County; Mrs. E. Roderick Shipley, President, Baltimore; Mrs. D. Delmas Caples, Baltimore County; Mrs. Gerald W. LeVan, Washington County; Mrs. Irene M. Bauersfeld, Montgomery County. Standing—Mrs. E. Ellsworth Cook, Jr., Baltimore; Mrs. W. Ross Cameron, Washington County; Mrs. William S. Stone, Baltimore; Mrs. Irving J. Taylor, Baltimore; Mrs. David S. Clayman, Prince Georges County; Mrs. Raymond V. Rangle, Baltimore; Mrs. Otto C. Brantigan, Baltimore; Mrs. Sam Allen, Montgomery County; Mrs. Whitmer B. Firor, Baltimore; Mrs. John G. Ball, Montgomery County.

INTRODUCING THE PRESIDENTS—

Nearing the end of her year as president of the Woman's Auxiliary to the Baltimore City Medical Society, Mrs. Raymond L. Markley said, "We have had a very enjoyable and profitable year and I want to thank the members of the Auxiliary, and especially the members of the Board, for their help."

Doris Markley has been active in the Auxiliary since 1953. In that year she was chairman of decorations for the first annual Med-Chi Ball; the following year she managed the program, and another year the ticket arrangements. She served as recording secretary and then as president-elect on the Auxiliary Board. In the State Auxiliary she served as membership chairman and, this past year, as historian on the State Board.

A native Baltimorean, Mrs. Markley majored in sociology and psychology at Western Maryland

College. She graduated in 1944 with a B.A. degree. During her four college years she was on the May Court. After graduation she was employed by the Baltimore City Department of Public Welfare as a case worker. She attended Strayer Business College at the same time and subsequently went to work as a medical secretary. Through this latter position she met Dr. Raymond Markley, whom she married in 1947.

After her husband's Army tour Doris Markley worked as a medical secretary in the Psychiatric Institute at the University Hospital. She was later



Photo by Bradford Bachrach
MRS. RAYMOND L. MARKLEY

appointed a research assistant in the Department of Psychiatry.

The Markleys now have a baby daughter, Mary Paula, who was born in May, 1958. Mrs. Markley's hobby is dogs. She owns several and has personally handled her prize Dalmatian at Shows in Annapolis, Timonium, Catonsville and Hagerstown. She is a member of the Woman's Board of the University Hospital and of Ascension Lutheran Church on York Road.

TOUR OF HOMES

MRS. E. ELLSWORTH COOK, JR., *Chairman*

MRS. PETER BALL, *Co-Chairman*

The Woman's Auxiliary to the Baltimore City Medical Society cordially invites all to a Hospitality Tour of five Baltimore doctors' homes, on Thursday afternoon, April 16, 1959, from 1 P.M. until 4 P.M. The committee has earnestly tried to give our guests a diversified tour of open homes which we've all been most anxious to see, either for their antiques, gardens, pools, architectures, or personalities. The proceeds of the tour will benefit the American Medical Education Foundation, to be divided equally between The University of Maryland School of Medicine and the Johns Hopkins University School of Medicine.

Tickets are \$1.50 and are available at any of the homes you visit—to be punched at the remainder of the homes on the tour. There will be a transportation pool of station wagons which will leave the Sheraton Belvedere Hotel at 12:45 P.M. and at 1 P.M. Sign for station wagons at the registration desk either on Wednesday, April 15 or Thursday morning.

Those homes whose owners have graciously consented to entertain you include:

Dr. and Mrs. John S. Haines—Blythewood. English stone manor house with gorgeous cherry trees and boxwoods rimming the swimming pool in the garden. Drive north on Charles Street past Cold Spring Lane and the Carrollton Apartments. The next road on your left will be Blythewood. Turn left from Charles to Blythewood and continue around drive to No. 25 which will be on your left.

Dr. and Mrs. Leslie N. Gay—"Gay Willows" in Roland Park. Ivy-covered stone mansion features a lifetime hobby of the Gays. Picturesque gardens and bird sanctuary. Drive north on Roland Avenue to Lake Avenue (dead end). Turn left on Lake and drive 2-3 city blocks to Hollins Road. Turn right on Hollins and drive downhill to driveway.

Dr. and Mrs. Irving J. Taylor—Dumbarton. Modern contemporary ranch style featuring a newly added family room and from the "Land of Pleasant Living"—a swimming pool. 3500 Southvale Road. Drive west on Park Heights Avenue to section where boulevard narrows, which will be Slade Avenue. Continue west on Park Heights approximately two blocks to Overbrook Road. Turn right and drive

about three blocks to house at dead end which will be the Taylors.

Dr. and Mrs. William S. Stone—Guilford. Residence in lovely Georgian style, adjacent to world-famous Sherwood Gardens. Drive north on St. Paul Street, turn right on Milbrook Road one block and turn right on Greenway and the fifth house on the right will be 4202.

Dr. and Mrs. Albert E. Goldstein—Homewood. This lovely Town House features a successful combination of doctor's office and gracious home and is across the street from the Johns Hopkins University Campus. What Baltimorean doesn't thrill to a drive along North Charles Street in the springtime? Drive north on Charles Street to 3505 where the Goldsteins have invited you to conclude your tour and meet your presidents, Mrs. E. Roderick Shipley and Mrs. D. Delmas Caples, and the representatives from our National Auxiliary, and have some refreshments.

BALTIMORE CITY'S MEDICAL RESEARCH COMMITTEE ANNUAL REPORT

MRS. HERBERT L. WARRES, *Chairman*

Our small animal project is a huge success! The school children love their pets; the teachers are most appreciative of the learning opportunity afforded; and we, their auxiliary visitors, are fascinated at every level.

Many of you will recall the background for our present cooperation with the Maryland Society for Medical Research as being the big legal dispute of 1951, when the antivivisectionists and the S.P.C.A. refused dogs for necessary experimentation in our medical schools. After the fight was won, Dr. C. Dietrich Smith, secretary of the M.S.M.R. and director of admissions at the Maryland Medical School, began a program aimed at educating the public, especially the youngsters in our schools, about the need for animals in the advancement of medical research.

In 1955 we of the Auxiliary began visiting school classes to demonstrate our interest in the animals delivered by the M.S.M.R. and to report back to Dr. Smith on their care, needs and the side benefits evidenced in the children. Aside from learning that animals can live useful and happy lives befriending and sparing mankind, the children get a real life lesson in food and health, loving care and procre-

ation. They learn the problems of care and feeding of white mice, rats, guinea pigs or hamsters. In the higher grades they perform genetic experiments which point up the theories of dominant and recessive characteristics, or carry out deficiency diet experiments which illustrate that the animals will suffer the same effects as humans, and vice versa, if certain nutrients are omitted from their bill of fare. They learn by doing and always return their animals to health after demonstrating their purpose. In addition, they are stimulated to write stories and reports. They learn cleanliness, do interesting art work with the animals as models, and rig up all kinds of ingenious equipment. They develop an enduring interest in science and its methods of control.

Perhaps some of you saw the article in the Sunday *Baltimore American* on January 25 on one of our projects. It was called "Mice are Welcome in Towson Pantry!" Incidentally, the names the children give their pets, and their reasons, have been most amusing and it has been interesting to compare the achievements of teachers and groups using similar props. Some are simply fabulous in their organization and efficiency—gloved teams of specialists, etc. Others, naturally, suffer by comparison.

This committee met with Dr. Smith for orientation last fall in the animal lab in the Bressler Building. Since then Adele Workman, Ella Stewart, Edith Taylor, Eleanor Lavenstein, Alice Radman, Alma Goldman, Miss Esther Crampton of M.S.M.R., and your chairman have made 30 visits. We have been notified of about 100 "deliveries" in the State. We are limiting ourselves to the city and its immediate environs, hoping the counties will develop their own visiting committees. We have 13 more city visits assigned but not yet completed.

1959 CONVENTION

The thirty sixth annual convention of the Woman's Auxiliary to the American Medical Association will be held in Atlantic City June 8 to 12. Headquarters will be at the Hotel Haddon Hall. Mrs. David B. Allman is chairman of the committee on local arrangements.

The tentative program schedule is as follows:

Saturday, June 6

Finance committee meeting.

Sunday, June 7

Registration (starting at noon). Meetings of the Board of Directors, and bylaws and resolutions committees.

Monday, June 8

Round table discussions:

A.M.E.F. — Bylaws — Bulletin — Finance — Membership — Parliamentary Procedure — Program Planning — Publications — Report Forms—Today's Health

The subjects for discussion in the round tables will be designed to cover auxiliary essentials on the basis of membership size and scope. There will be three rooms—one for auxiliaries with memberships under 1,000; one for memberships 1,000 to 2,000 and one for memberships over 2,000. Members will be asked to select the room of their membership category and remain in that room for the entire round table program.

The National chairmen will plan their material to cover three different presentations on the basis of the above membership categories. They will move from room to room on a designated schedule. The chairmen are hopeful this new plan will make it possible for them to present their ideas and suggestions on a more individualized basis that will more closely fit the needs of the varying size groups. County officers and chairmen are urged to attend and avail themselves of this opportunity to hear and discuss local problems and situations.

Round tables will include, or be a substitute for, reports usually given by the National chairmen. Data posters on A.M.E.F., Bulletin Circulation, Membership and Today's Health (by state) will be on display all during the convention. This will make it unnecessary for the National chairmen to report on these projects and also make it possible for the state presidents to eliminate such data from their brief reports at convention.

Later in the afternoon, the annual Tea honoring the president and the president elect will be held. Pfizer and Company will be hosts to the Auxiliary on this occasion.

Tuesday, June 9

General meeting and luncheon in honor of the National past presidents. Guest speaker will be announced later.

During the general meeting, there will be a talk on current and important legislation by guest speakers from the American Medical Association Law Division. A prominent Army officer will also present an interesting and constructive program on survival medicine in national defense.

Wednesday, June 10

General meeting (until noon) and luncheon in honor of the National president and president elect. Dr. Gunnar Gundersen, president of the American Medical Association, will be the guest speaker. Invited guests will be the members of the advisory council from A.M.A. to the Auxiliary and their wives, and the members of the Board of Trustees and their wives.

A safety demonstration by the director of Chicago's Traffic Safety Board will be given during the meeting. The chairman of the National Community Service Committee will also make a report.

Following the luncheon there will be a program of films on Crusade for Freedom, mental health and recruitment; also a demonstration by Carol Lane of the National Safety Council and Shell Oil Company. Facilities will be available for showing slides of out-

standing auxiliary projects. Presidents who wish to do this are asked to send their slides to the Central Office not later than April 15 for viewing by a committee.

Thursday, June 11

General meeting (until noon). Meeting of the Board of Directors will be held at one o'clock, followed by informal discussion of committee programs for 1959-60 with the committee chairmen and the Board of Directors.

The annual dinner will not be held this year.

Friday, June 12

Postconvention workshop of state presidents, presidents-elect and National committee chairmen. Members invited.

Hotel reservations should be made as soon as possible. A list of hotels appears in the *Journal of the American Medical Association*. Send your reservations to Dr. Robert A. Bradley, chairman housing committee, Convention Bureau, 16 Central Park, Atlantic City, New Jersey, on the form provided in the J.A.M.A. Be sure to mention the Woman's Auxiliary when you place your reservation.

DON'T FORGET

*Annual Meeting
Medical and Chirurgical Faculty
April 15, 16, 17, 1959
The Alcazar
Baltimore*

MARK THE DATE

CALENDAR OF EVENTS

TUESDAY, APRIL 14, 1959

BALTIMORE EAR, NOSE AND THROAT SOCIETY

6:15 P.M. Cocktails, 7:00 P.M. Dinner, 8:00 P.M. Meeting
University Club, Charles Street at Madison

**WEDNESDAY, THURSDAY,
FRIDAY, APRIL 15, 16 AND
17, 1959**

ANNUAL MEETING OF THE MEDICAL AND CHIRURGICAL FACULTY

The Alcazar, Cathedral and Madison Streets, Baltimore,
Maryland

FRIDAY, APRIL 17, 1959

MARYLAND PSYCHIATRIC ASSOCIATION AND SETON INSTITUTE. COMBINED MEETING

8:30 P.M., Seton Institute
Dr. Tigani El Mahi, member of the Administrative Board of the World Federation for Mental Health and vice chairman for the First Conference on Mental Health in Africa, will speak on "Psychiatry in Primitive Society."

MONDAY, APRIL 20, 1959

ORTHOPAEDIC SECTION, B.C.M.S.

4:30 P.M., Sheraton Belvedere
This will be a joint meeting with the Washington Orthopaedic Club.
Program to be announced. Cocktails and dinner to follow

TUESDAY, APRIL 21, 1959

RADIOLOGICAL SECTION, B.C.M.S.

5:30 P.M. Medical Residence Hall, Johns Hopkins Hospital

**MONDAY AND TUESDAY,
APRIL 27 AND 28, 1959**

AMERICAN VENEREAL DISEASE ASSOCIATION—ANNUAL MEETING

In cosponsorship with the United States Public Health Service of the Tenth Annual Symposium on Recent Advances in the Study of Venereal Diseases.
Johns Hopkins Hospital Auditorium.